In The

Supreme Court of the United States

October Term, 1978

No. 78-389

LESLIE KAYE, BARUCH GLOBERMAN, and SOL MALLOW, As Operators of the SANS SOUCI NURSING HOME; EMANUEL BIRNBAUM and DESDEMONA JONES, As Operators of the FIELDSTON LODGE NURSING HOME; and THE NEW YORK STATE HEALTH FACILITIES ASSOCIATION, INC., A New York Not-For-Profit Membership Corporation, Suing On Behalf Of Its Member Licensed Nursing Homes and Health Related Facilities Located Within The State of New York,

Appellants,

v.

ROBERT P. WHALEN, As Commissioner of Health Of The State Of New York; and PETER GOLDMARK, As Director Of The Budget Of The State Of New York,

Appellees.

On Appeal From The Court Of Appeals Of The State Of New York

JURISDICTIONAL STATEMENT

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JURISDICTIONAL STATEMENT

THE OPINIONS BELOW

The Memorandum Decision of the Court of Appeals of the State of New York is reported at 44 N.Y. 2d 754 (1978) and appears herein as Appendix "A". The previous intermediate state appellate court decision of the Appellate Division-Third Department of New York State Supreme Court is reported at 56 App. Div. 2d 111 (1977) and appears herein as Appendix "B". The

state trial court decision of the Supreme Court of the State of New York (Special Term, Albany County) is unreported and is reproduced herein as Exhibit "C". No other written opinions have been delivered.

STATEMENT OF THE GROUNDS ON WHICH THE JURISDICTION OF THIS COURT IS INVOKED

(i) Appellants, the licensed operators of several skilled nursing and/or intermediate care facilities located in New York State, and the New York State Health Facilities Association, Inc., a not-for-profit membership corporation representing over two hundred such facilities with over 30,000 beds in New York State, initiated this class-action in state court in New York on behalf of themselves and all similarly situated facilities in New York which participate in that State's federally funded medical assistance ("Medicaid") program, established pursuant to Title XIX of the Social Security Act, 42 USC §1396 *et seq.* This lawsuit challenges the constitutionality of the system and methodology established by New York State law and regulations for reimbursing such facilities for services rendered to New York State under its Medicaid program after January 1, 1976.

Appellants contend that New York State's law and the regulations implementing it, including but not limited to the retroactive portion thereof, which establish that State's reimbursement system after January 1, 1976, are invalid as repugnant to the Supremacy Clause (Art. VI, cl. 2) and the Contracts Clause (Art. I. §10) of the United States Constitution as well as the Fifth and Fourteenth Amendments thereto. The State's Trial Court (New York Supreme Court, Albany County, Special Term) found in favor of Appellants' attack against the constitutionality of the statute, but the State's intermediate appellate court (New York State Supreme Court, Appellate Division-Third Department), narrowly reversed in a 3-2 Decision, 56 App. Div. 2d 111 (1977), and the State's highest

court, the Court of Appeals, affirmed the Appellate Division's decision. 44 NY 2d 754 (1978).

(ii) The ruling sought to be reviewed by this appeal is the Decision of New York State's Court of Appeals (44 NY 2d 754), dated April 25, 1978, upholding the constitutionality of the reimbursement statute and regulations. Judgment pursuant to that decision was entered in New York State Supreme Court, County of Albany, on May 11, 1978. A copy of that Judgment is reproduced herein as Appendix "D". A Motion for reargument made by Appellants to the New York State Court of Appeals was also denied on June 6, 1978, and a judgment pursuant thereto was entered in New York State Supreme Court, Albany County, on June 16, 1978. A copy of said Judgment is annexed hereto as Appendix "E". Notices of Appeal from both decisions and judgments were filed on July 13, 1978 in both the New York State Court of Appeals and the New York State Supreme Court, Albany County. Said Notices of Appeal are annexed hereto as Appendices "F" and "G", respectively.

(iii) Jurisdiction of this appeal is conferred upon this Court pursuant to 28 USC §1257(2).

(iv) Cases sustaining the jurisdiction of this Court are

Allied Structural Steel Company v. Spannaus, 98 S. Ct. 2716 (1978)

United States Trust Co. of New York v. New Jersey, 431 U.S. 1 (1977)

Dodge v. Board of Education of the City of Chicago, 302 U.S. 74 (1937)

International Steel and Iron Co. v. National Security Co., 297 U.S. 657 (1936)

(v) The validity of subdivision 2(e) of §2807 of the Public Health Law of the State of New York (N.Y. Pub. Health Law, §2807(2) (e), [McKinney 1977]), enacted on March 30, 1976,

pursuant to §11 of chapter 76 of the Laws of 1976 of the State of New York (1976 N.Y. Laws, chapter 76, §11) is here involved. It reads as follows:

> *During the period beginning January first, Nineteen Hundred Seventy-Six, and ending March thirty-first, Nineteen Hundred Seventy-Seven,* the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities *without regard to the provisions of subdivision three of this section.* The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph notwithstanding any inconsistent provision of section twenty-eight hundred eight. (Emphasis Added.)

Also involved are the reimbursement regulations published on October 22, 1976 by the Commissioner of Health for the State of New York pursuant to the above statute and made retroactive to January 1, 1976. These regulations are contained in Part 86-2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York. 10 NYCRR §86-2.1 *et seq.*. They are set forth more fully in Appendix "H".

Subdivision 3 of §2807 of the Public Health Law of the State of New York (N.Y. Pub. Health Law, §2807(3) [McKinney 1977]), referred to in and limited by the above quoted statute, had, prior to the enactment of the above-quoted statute, mandated that Medicaid rates determined by the Commissioner of Health of the State of New York and certified by the State Director of the Budget be "reasonably related to the costs of efficient production of such (Medicaid) services." Subdivision 3 of §2807 is reproduced in Appendix "I". The constitutionality of the italicized language in the above statute, N.Y. Pub. Health Law, §2807(2)(e), quoted in full, which directs a retroactive departure from the previous standard of reasonable cost-related reimbursement theretofore mandated by §2807(3), is the main issue in this case.

QUESTIONS PRESENTED BY THE APPEAL

(i)

The Medical Assistance (Medicaid) Program is a federal grant-in-aid program enacted by Congress to partially reimburse those states which voluntarily elect to participate in the program for the costs they incur by agreeing to provide certain kinds of basic medical care, including nursing home care, to their medically needy indigent residents who could not otherwise afford such care. Among the conditions imposed by federal law for participation by a State in the program is that the State establish a system of reasonable cost-related reimbursement to facilities providing such nursing home care in order to ensure that a certain minimum level of quality care is provided. The first question presented by this appeal is whether a State, wishing to continue its participation in the program but faced with a severe financial crisis, may, without violating the Supremacy Clause (Art. VI, cl. 2) of the United States Constitution, enact laws and regulations which abandon the federally required reasonable cost-related reimbursement system in order to limit its (the State's) budgetary expenditures.

(ii)

Federal law requires states participating in the Medicaid Program to adopt a reasonable cost-related Medicaid reimbursement system for nursing homes by July 1, 1976. The second question presented by this appeal is (a) whether a state statute adopting a different reimbursement system effective after July 1, 1976 violates the Supremacy Clause and (b) whether such noncompliance was or could be waived by a letter from a federal bureaucrat which the State alleges delayed the deadlines set by federal law.

(iii)

The same federal statute requiring states to adopt a reasonable cost-related reimbursement system also mandated that such system must first receive the prior approval of the United States Secretary of Health, Education and Welfare (HEW). The third question presented by this appeal is whether a state statute, and especially the regulations enacted pursuant thereto, which adopted a Medicaid reimbursement system violate the Supremacy Clause if they are implemented without prior federal approval and are, in fact, later specifically disapproved by HEW for failure to satisfy federal reasonable cost-related reimbursement requirements. A related question is whether nursing home facilities challenging the constitutionality of such regulations must prove that the regulations fail to satisfy federal requirements or merely show that State officials failed to receive prior federal approval and that, indeed, HEW specifically rejected the State's reimbursement regulations.

(iv)

When New York State adopted the Medicaid reimbursement statutes and regulations challenged herein, they applied them retroactively, which had the effect of reducing Medicaid rates for periods in which the Appellants herein had already rendered Medicaid services to the State. The State had already paid Appellants at the previous higher reimbursement rates. These facilities had originally agreed to participate in the program by executing so-called "Provider Agreements" with the State, pursuant to which they were to be reimbursed under the reimbursement methodology then in effect in the State, which methodology was, of course, changed by the retroactive legislation challenged herein. The fourth question presented by this Appeal is whether that legislation, retroactively reducing rates, unconstitutionally impaired Appellant's contractual rights and divested them of their property without just compensation or due process of law.

STATEMENT OF THE FACTS OF THE CASE

For the past several years, Appellants have participated as providers of skilled nursing and intermediate care facility services* in New York State's Medicaid Program, which was established by Congress in the mid-1960's pursuant to Title XIX of the Social Security Act, 42 U.S.C. §1396 *et. seq.*

Each State has the option of choosing to participate in the program; if it does, a portion of its cost in administering the program is reimbursed by the federal government.** New York has participated in the Medicaid Program since its inception. In order to do so, it was required to file with the U.S. Secretary of HEW its so-called "State Plan for Medical Assistance," which the Secretary had to approve before New York's program could become operational. 42 U.S.C. §1396.

Under federal law, facilities, such as those operated by the Appellants, are reimbursed at rates established by the States for services these facilities render as providers of care under the program. Appellees herein, the Commissioner of Health for the State of New York and the Director of the Budget of the State of New York, are the two officials vested with responsibility under New York State law for establishing Medicaid reimbursement rates for such facilities. N.Y. Pub. Health Law. §2807, 2808 (McKinney 1977).

For many years, States participating in the program were free to establish whatever reimbursement rates they wished for providers of skilled nursing and intermediate facility care. There was no requirement that a certain minimum level of reimbursement be paid. In 1972, however, amid widespread reports of

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*These services are defined in 42 U.S.C. §1396d(d) and (f).

**The percentage of federal financial participation in any State's Program is computed pursuant to a complex formula. 42 U.S.C. §1396b. The amount of federal financial participation in New York State's program is 50%.

scandalous conditions existing in many nursing homes,* Congress enacted §249(a) of Public Health Law 92-603, which amended 42 U.S.C. §1396a by adding thereto a new subsection, (a) (13) (e), which provided that after July 1, 1976, States participating in the program must reimburse skilled nursing and intermediate care facilities on a "reasonable cost-related basis" pursuant to "methods and standards developed by the State on the basis of cost finding methods approved and verified by the Secretary" of HEW.

This posed no problem for New York State since it had already adopted, several years before, a reasonable cost-related Medicaid reimbursement system for nursing homes. Subdivision 3 of §2807 of the N.Y. Public Health Law (Appendix "I"), specifically governing such reimbursement, provided in pertinent part that in adopting such rates:

> . . . the Commissioner shall determine ... that the proposed rate schedules ... are *reasonably related to the costs of efficient production* of such services ..." (Emphasis Added).

Pursuant to this statutory mandate, Appellees and their predecessors in office had adopted a set of reimbursement regulations (which had the full force and effect of law) governing Medicaid reimbursement on a calendar year basis for nursing homes and related health care institutions in New York. Those regulations were contained in Part 86 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, 10 NYCRR Part 86, more commonly referred to as "Part 86". Through the end of 1975, Appellants were reimbursed pursuant to Part 86.

When, however, it came time to establish rates for 1976 pursuant to Part 86, Appellees, instead of applying those

*See, for example, a series of articles appearing in the *N.Y. Times* in October, 1974, especially October 7, 1974 at 40, col. 5.

regulations, simply froze rates at 1975 levels. Had the Part 86 regulations been applied, as required by State law, the rates for 1976 would have been much higher than 1975 levels, since the facilities' costs, on which Part 86 reimbursement would have been based, had skyrocketed. Sudden huge increases in energy costs and double-digit inflation had combined with a whole set of new services to be provided by nursing homes (as mandated by laws enacted during New York's 1975 Legislative Session*) to increase substantially the cost of operating a nursing home in New York State.

The rate freeze imposed by Appellees, although undertaken without any statutory authority whatever, was instituted as part of the State's policy to deal with its own dire financial condition, which had been in large measure precipitated by the fiscal woes of New York City. Appellants, however, had serious financial problems of their own and were concerned that they were about to be made the innocent victims of the State's fiscal problems. Accordingly, they instituted this class-action lawsuit in New York State Supreme Court, on behalf of themselves and all similarly situated Medicaid providers in New York State, demanding that Appellees, as the appropriate State officials charged with responsibility for setting reimbursement rates, reimburse them at rates calculated in accordance with Part 86 as required by State law and the "provider agreements"** which

*1975 N.Y. Laws, Chapters 649-660, inclusive.

**"Provider Agreements" are the contracts required under the federal Medicaid Law, 42 U.S.C. §1396a(a)(27), to be executed between the providers of Medicaid services and the State. A typical provider agreement appears in Appendix "J". These agreements called for Appellants to provide services "... in consideration of receiving payments for services provided to individuals receiving assistance under the New York State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act." That State Plan, previously approved by the Secretary of HEW, included the Part 86 reimbursement regulations.

they had executed with the State. Appellants also claimed that the freezing of rates violated federal law as well in that the departure from the State's previous reimbursement methodology had not received the prior approval of HEW and that the frozen rates could not be reasonably cost-related, as required by federal law, 42 U.S.C. §1396a (a) (13) (e), after July 1, 1976.

As previously stated, there existed no defense, statutory or otherwise, to Appellants' lawsuit and the Appellees' formal Answer to Appellants' Petition was merely that proposed legislation, then pending before New York's Legislature, would retroactively ratify the freeze.

On March 30, 1976, new legislation was enacted in New York State. While it did not ratify the freeze, it did adopt a new set of laws, known as Chapter 76 of the Laws of 1976 (1976 N.Y. Laws, ch. 76) designed to deal with the fiscal crisis then facing the State. Section 11 of Chapter 76 amended §2807 of the Public Health Law of the State of New York by adding thereto a new subdivision, 2e, which has already heretofore been quoted in full. (*Supra*, at p. 4). That subdivision, which was retroactive to January 1, 1976, stated that Appellees were to adopt new Medicaid reimbursement regulations, effective as of January 1, 1976 which were to be adopted "... without regard to the provisions of subdivision 3 ..." of §2807 of the Public Health Law. It was subdivision 3, of course, which until then, had provided for reimbursement on a reasonable cost-related basis.

The Legislature had, therefore, as a means of limiting its expenditures in an effort to solve the State's fiscal problems, directed that the State abandon its previous policy of reimbursing nursing homes on a reasonable cost-related basis.

Justice Ellis J. Staley, Jr., the New York State Judge before whom Appellants' suit demanding reimbursement pursuant to Part 86 was then pending, specifically asked counsel for both sides to brief the Court as to what the impact, if any, the

enactment of Chapter 76 had on Appellants' claim for reimbursement pursuant to Part 86.

Appellants argued strenuously that ch. 76 was patently unconstitutional since its retroactive application to January 1, 1976 would impair Appellants' contractual rights to receive payments under the old Part 86 regulations as required by Appellants' provider agreements with the State. This was especially true of payments for services that had already been rendered prior to the enactment of ch. 76. Moreover, Appellants contended that the regulations, since they obviously mandated a departure from reasonable cost-related reimbursement, as required by federal law after July 1, 1976, violated the Supremacy Clause of the United States' Constitution.

In the meantime, while both sides awaited Justice Staley's ruling, months passed, with Appellants still being paid at the frozen 1975 rates since new rates could not yet be published because the new reimbursement regulations, mandated by ch. 76, had not yet been promulgated. To further complicate the issue, the Commissioner of Health, after the enactment of ch. 76 but before the promulgation of new reimbursement regulations implementing the law, apparently recognized that there were no reimbursement regulations which would apply to the interim period before new regulations were published. Accordingly, he issued the following regulation, 10 NYCRR §86.34, which made it clear that the old Part 86 regulations were to remain in effect for purposes of reimbursement until new regulations were passed:

> §*86.34 Interim rates for residential health care facilities.* For the purpose of reporting and rate certification for residential health care facilities, the provisions of this Part in effect on October 8, 1975, shall remain in effect for an interim period until new regulations have been promulgated pursuant to §§2807 and 2808 of the Public Health Law.

However, notwithstanding the unequivocal language of this, the Commissioner's own regulation, he steadfastly refused to pay rates pursuant to Part 86.

Finally, in November, 1976, the new reimbursement regulations, 10 NYCRR §86-2.1 *et seq*, so-called "Part 86-2," were promulgated. They were devastating. In the vast majority of cases (417 to be exact), facilities' rates were even lower than the 1975 frozen rates, to say nothing of how much lower they would have been than the rates which would have been in effect had Part 86 been applied. Since the new rates were not published until November, 1976 and were made retroactive to January 1, 1976, the effect was to cause an immediate liability to the State of over $34.3 million (by the State's own estimate) for those facilities which until November 1, 1976, had been paid pursuant to the higher frozen rates.

In the meantime, Justice Staley issued his decision (Appendix "C") in September, 1976 sustaining Appellants' attack on the constitutionality of ch. 76,* and granting Appellants' demand that they and all similarly situated facilities in New York State be reimbursed in accordance with Part 86, retroactive to January 1, 1976. Justice Staley held that although the State, as a sovereign power, certainly had the power to enact new laws, it could not do so in a manner that would constitute a unilateral abrogation of its contractual obligations with the Medicaid providers by changing the methodology of reimbursement to which it (the State) had committed itself to the facilities for the duration of the provider agreements then in effect. Justice Staley also ruled that the State had violated the federal statutory law governing the Medicaid program since the changes in reimbursement methodology had not received prior federal

*Appellants were unable, however, to enjoy the fruits of their victory since the State immediately appealed the decision, which, under New York State law, meant that it was entitled to an immediate stay of the decision appealed from. N.Y. Civ. Prac. 5519(a)(1).

approval. Justice Staley ordered that Appellees recompute Medicaid reimbursement rates for the entire class of facilities based on the Part 86 regulations in effect on January 1, 1976.

The State appealed to the Appellate Division-Third Department of New York State Supreme Court which reversed the lower court determination in a 3-2 decision, *Matter of Kaye v. Whalen*, 56 App. Div. 2d 111 (1977) Appendix "B"), notwithstanding a vigorous dissent. The Appellate Division upheld the constitutionality of the new law, which retroactively reduced rates, thereby authorizing the State to recoup at least $34.3 million in payments already made for services rendered to the State by the facilities between January 1, 1976 and November 1, 1976. The majority opinion rejected Appellants' constitutional attack on chapter 76 of the Laws of 1976, and ruled that this State law did not violate federal law even though the U.S. Secretary of HEW had not given prior approval to the change in the State's reimbursement methodology and even though the law departed from the reasonable cost-related reimbursement standards which Congress had mandated to take effect after July 1, 1976. The Appellate Division majority ruled that although Congress had passed a law establishing the July 1, 1976 deadline, a bureaucrat in HEW had sent a letter dated September 30, 1976 (Appendix "L") implying that the deadline for states to comply with the regulation had been extended by administrative fiat to January 1, 1977, and that this justified the State's noncompliance with the regulation. The Appellate Division also ruled that Appellants had not demonstrated that the new reimbursement regulations violated federal reasonable cost-related standards.

Appellants then appealed to New York's highest court, the Court of Appeals. In the meantime, HEW had specifically advised the State by letter dated July 12, 1977 (Appendix "K") that the State's reimbursement methodology challenged by Appellants violated federal reasonable cost-related reimbursement

standards. The New York Court of Appeals, however, ignored the letter (although Appellants' Brief specifically directed the Court's attention to it) and affirmed the Appellate Division's Decision. *Matter of Kaye v. Whalen*, 44 NY2d 754 (1978). The Court rejected Appellants' argument that the law retroactively reducing reimbursement rates impaired the State's contractual obligations, reasoning that although Appellants were not paid pursuant to Part 86 regulations, their provider agreements with the State did not establish a specific rate and thus a change in rate did not violate the agreements.

This ruling overlooked the simple fact that although the provider agreements did not specify a rate, they did incorporate Part 86 regulations, the application of which would have yielded a specific rate. It was the failure to apply the Part 86 regulations which Appellants had contended constituted the breach of the contract. The provider agreements (Appendix "J"), required under federal law, 42 USC §1396a(a)(27), stated that the facilities were performing services "in consideration of receiving payments for services provided to individuals receiving assistance under the New York State Plan for Medical Assistance ...". That Plan specifically included the Part 86 reimbursement methodology. By directing the State officials to adopt a reimbursement system different from Part 86, Appellants had insisted that the chapter 76 legislation clearly violated the provider agreements and, therefore, the facilities' rights to reimbursement under Part 86.

The Court also rejected Appellants' argument that the new legislation, directing a departure from the reasonable cost-related reimbursement standards, violated the Supremacy Clause since it caused the State to fail to meet the Congressionally mandated deadline for reasonable cost-related reimbursement of July 1, 1976. The Court's rationale for rejecting this argument was predicated on the same bureaucratic letter (Appendix "L") cited by the Appellate

Division, which the State relied on as proof that HEW did not require a July 1, 1976 deadline, despite a specific federal law to that effect.

Finally, the New York Court of Appeals, like the Appellate Division's majority opinion, stated that Appellants had not shown, in any event, that the State's new reimbursement regulations failed to satisfy federal reasonable cost-related reimbursement standards. It should be emphasized again that the Court, however, never acknowledged HEW's July 12, 1977 letter (Appendix "K") stating that the regulations failed to satisfy federal requirements. The Court of Appeals also ignored 42 USC §1396a (a) (13) (E) and 42 CFR 450.30 (a) (3), which clearly stated that prior approval by HEW was necessary before new reimbursement regulations could be applied.

Appellants moved for reargument which was denied by decision of the Court of Appeals on June 6, 1978 and judgment pursuant thereto was entered on June 16, 1978. By virtue of that decision, the State is now taking steps to effectuate the recoupment of over $34.3 million from nursing homes, which sums had already been paid to the facilities prior to November 1, 1976. Thereafter, and also by virtue of the same decision, the State continued to pay facilities for the balance of 1976 and all of 1977 at rates calculated pursuant to the new 1976 regulations which never received prior federal approval, instead of pursuant to the old Part 86 regulations, which had been a reasonable cost-related methodology, required and approved by federal law.

Appellants by this appeal continue to insist that for 1976 and 1977, their reimbursement should have been based on the old Part 86 regulations, and that the State statute, chapter 76 of Laws of 1976, retroactively adopting a different reimbursement system, was patently unconstitutional because it (a) specifically contradicted federal law in violation of the Supremacy Clause and (b) retroactively divested Appellants of payments already received for services rendered, thereby violating the Contracts

Clause and the Just Compensation and Due Process Clauses of the Fifth and Fourteenth Amendments.

THE FEDERAL QUESTIONS PRESENTED ARE SUBSTANTIAL

(i) *A Vital National Concern Is Directly Affected By The Issues Raised In This Appeal*

There are numerous substantial federal constitutional questions involved in this Appeal. The New York statutes and regulations challenged herein raise important issues concerning the Supremacy Clause, the Contracts Clause, and the Just Compensation and Due Process Clauses of the Fifth and Fourteenth Amendments to the U.S. Constitution. Moreover, the decision of the New York State Court of Appeals appealed from herein is directly in conflict with decisions rendered by several other federal courts on the same issue. In addition, large sums of money (in the magnitude of literally tens of millions of dollars) are at stake. The substantial and non-frivolous nature of Appellants' case is evidenced by the fact that the state trial court resolved all of these issues in Appellants' favor, and thereafter the New York State Supreme Court, Appellate Division-Third Department (although it reversed the lower court decision) did so only by a narrow 3-2 majority over a very strong dissent. This Jurisdictional Statement will hereinafter elaborate more fully on the legal issues involved; before doing so, however, it is appropriate to emphasize that this appeal also concerns issues of vital national importance.

The quality of care being given to the significantly large portion of the elderly population residing in nursing homes in this country is an important public issue. There have, in fact, been numerous reports of scandalous conditions existing in many of this Nation's nursing homes and health-related institutions.

One of the major causes identified by Congress as contributing to the problem was the inadequacy of funding by some states to pay for quality care. This is why Congress enacted §249(a) of Public Law 92-603, 42 USC §1396a(a)(13)(E), which required that the states participating in the program and receiving federal funds (and which were responsible for reimbursing nursing homes and other health-related institutions providing care under the Medicaid program) must reimburse its facilities on a reasonable cost-related basis.

As previously set forth, New York State, however, concerned with its own fiscal problems, enacted the legislation now under attack in this appeal, which legislation specifically departed from the reasonable cost-related reimbursement methodology in order to save State funds.

Whether New York's action can be justified under the circumstances of its own serious financial conditions is an important consideration in this case with potential nationwide ramifications. Many other states, also faced with mounting budgetary deficits and taxpayer revolts spawned by the success of "Proposition 13" in California, will be watching the outcome of this appeal closely.

By what right, if any, can a state, while continuing to participate voluntarily in a federally funded program, ignore federal conditions for such participation in the program, just because of the fiscal impact the program will have on that state? Also, what protection against Medicaid cutbacks have the elderly poor of this country, who depend on Medicaid, and who are perhaps the single most vulnerable political group in our society, since they are least able, by virtue of their age and poverty, to mount effective political opposition to such cuts? These are the significant national public policy issues raised by this appeal.

(ii) ***A State's Financial Condition Does Not Justify Its Non-Compliance With A Federally Funded Program In Which The State Voluntarily Chooses To Participate; To Hold Otherwise Would Threaten The Integrity Of The Medicaid Program, Defeat The Congressional Intent Of Insuring Quality Care, and Violate The Supremacy Clause Of the United States Constitution***

There can be no doubt as to what prompted the State of New York's attempt to enact chapter 76 of the Laws of 1976, retroactively reducing the level of Medicaid reimbursement it paid to nursing homes and intermediate care facilities. The very first section of chapter 76 makes its intention altogether clear. It states in pertinent part:

> . . . It is recognized, that the State and local governments are facing emergency fiscal crises of staggering proportions, and cannot continue to support the scope and level of assistance, care and service the cost of which has sharply escalated in recent years. In order to assure that funds are available for essential and critical medical services, that basic medical necessities for the needy are provided and that critical assistance, care and health services will be available to all people of the State, the legislature, pursuant to the Constitution of the State of New York, hereby finds and declares that a state of emergency exists and hereby confers emergency powers upon the governor to take such steps as are necessary to implement the following controls on medical assistance and public assistance expenditures. 1976 N.Y. Laws, chapter 76, §1 (McKinney 1976)

Governor Carey, in signing the bill, acknowledged that the law had serious constitutional deficiencies. His Executive Memorandum, accompanying his signature on the bill, stated in pertinent part:

> . . . The Regional Director (Region II) of the Department of Health, Education and Welfare has written to express the Department's concern over certain provisions in the bill.

> The expenditure savings projected under the bill are essential to achieve a balanced budget and because of the urgent need to present such a budget for the State of New York, I must sign the measure into law . . . 1976 N.Y. Laws at 2433 (McKinney, 1976).

While, as a general proposition, no one can question the wisdom of the State's taking measures to put its own fiscal house in order, there can also be no question that it must do so in a constitutional manner. In the instant case, and pursuant to the general policy articulated in Section 1 of chapter 76, *supra*, the New York Legislature enacted Section 11 of chapter 76, the statute at issue in this case, which directed the Commissioner of Health of the State of New York to set reimbursement rates after January 1, 1976 for nursing homes "without regard to the provisions" of subdivision (3) of §2807 of the Public Health Law, which until that time, had specifically required reimbursement on a reasonable cost-related basis. *See* Appendix "I". Chapter 76 was, therefore, a specific legislative mandate and directive by the New York Legislature to the Appellees to depart from the standard of reasonable cost-related reimbursement required by federal law.

If Medicaid were merely a state operated program, this would raise no constitutional objections. Medicaid, however, is a federal-state grant-in-aid program, and a substantial portion of the State's costs in administering the program are federally financed. In fact, New York State receives 50% reimbursement for the costs of operation of its program from the federal government. As previously stated, federal law, enacted some four years prior to New York's legislation, had imposed a deadline on the States of July 1, 1976 by which time they were required to adopt a reasonable cost-related system of reimbursement in order to insure that quality of medical care be maintained. It is obvious, however, that just when federal law became effective to require reasonable cost-related reim-

bursement, New York State specifically departed from that system.

Surely, the State has no right to ignore such a federal mandate when it elects voluntarily to participate in a federally funded program. Otherwise, states could readily ignore federal requirements and still receive federal money. To do so, however, would surely run afoul of the Supremacy Clause of the United States Constitution. It would, as well, frustrate the federal policy involved in this case of insuring adequate reimbursement for nursing homes in order to enable them to provide quality care. The holding in this case is directly contrary to *Catholic Medical Center of Brooklyn and Queens v. Rockefeller,* 430 F. 2d 1297 (2 CA, 1970) aff'g 305 F. Supp. 1256 (E.D. N.Y., 1969); app. dsmd. 400 US 931 (1970) and *Alabama Nursing Home Association v. Califano,* 433 F. Supp. 1325 (M.D. Ala., 1977.)

If the decision below is allowed to stand, it will be a signal to other states that they too will be able, with impunity, to reduce reimbursement of nursing homes under their Medicaid programs below reasonable cost-related standards, notwithstanding a specific Congressional mandate to the contrary.

Lest there be any doubt about Congress' intent in this case, it is appropriate to review the issue of the Federal Register which contained the regulations promulgated by HEW implementing the federal reasonable cost-related reimbursement requirements embodied in 42 USC §1396a(a)(13)(E). It states:

> . . . (A) State would not satisfy the requirement . . . if it paid or gave assurance to pay, the amount determined under this section to the extent that State funds are available, or to the extent that State appropriations permit. To allow a state to limit its obligations under the statute by such provisions, as some comments suggested, would permit a state to defeat a major part of Congress' purpose in enacting Section 249. 41 Fed. Reg. 27,313 (1976).

Moreover, as Judge Frank Johnson emphasized in *Alabama Nursing Home Association v. Califano, supra:*

> The principal defense raised by the State is that the Alabama Legislature has appropriated insufficient funds to pay for the increase in expenditures which would result from having to set rates on a completely cost-related basis. However, inadequate funding does not excuse failure to comply with federal standards . . . there is no provision, express or implied, in the Social Security Act permitting the State to alter federal standards to suit its budgetary needs. State participation in Social Security Act programs are voluntary, and the State may withdraw if it wishes. But, if it remains in the program and accepts federal funds, it must follow the federal statute. *Rosado v. Wyman,* 397 US 397 (1970). If a state could evade the requirements of the Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will. The conditions which Congress has laid down for state participation in Medicaid and other programs would be utterly meaningless. That obviously is not the case.

Unfortunately, the State's highest court in the present case seems to have been altogether too concerned about the condition of its own sovereign's financial woes to worry about the serious Supremacy Clause questions raised by the New York State Legislature's obvious departure from federal law.

(iii) *The Decision Appealed From Ignored The Federally Imposed Deadline Of July 1, 1976 For Reasonable Cost-Related Reimbursement*

One of the reasons advanced by the decision appealed from for rejecting Appellants' argument was that an HEW official, by letter dated September 30, 1976, had indicated to the State that cost-related reimbursement regulations could not be implemented by July 1, 1976. (44 N.Y. 2d at 755). A copy of said letter is annexed hereto as Appendix "L". Such reasoning by the

court below was, at best, highly specious. In the first place, that letter was grossly misconstrued by the Court. The letter states in pertinent part:

> As you know, regulations . . . require that effective July 1, 1976, payment for skilled nursing facilities and intermediate care facility services must be on a reasonable cost-related basis . . .

Secondly, even if the letter did say (which it most emphatically did not) that the State need not meet the federal reasonable cost-related reimbursement deadline of July 1, 1976, no federal bureaucrat has the authority unilaterally to delay the effective date of a federal statute. Moreover, at least five other federal court decisions, in five different jurisdictions, have all stated that the federal reasonable cost-related deadline of July 1, 1976 means July 1, 1976, not some other, later date. Those decisions are

> *(a) Alabama Nursing Home Association v. Califano,* 433 F. Supp. 1325 (M.D. Ala., 1977)
>
> *(b) Golden Isles Convalescent Center v. Califano,* (USDC, S.D. Fla. — decided October 18, 1977 — Docket No. 76-1810-Civ.-WMH; Medicare and Medicaid Guide [CCH], ¶28, 710)
>
> *(c) Wisconsin Association of Homes For The Aging v. Caballo,* (USDC, E.D. Wis., decided December 1, 1977 — Docket No. 76-C-78; Medicare and Medicaid Guide [CCH], ¶28, 713)
>
> *(d) Nebraska Health Care Association v. Exon,* (USDC, Neb., decided December 8, 1977 — Docket No. CV 77-L-41; Medicare and Medicaid Guide [CCH], ¶28, 712)
>
> *(e) Illinois Health Care Association v. Califano,* (USDC, N.D. Ill.; decided December 14, 1977; Medicare and Medicaid Guide [CCH], ¶28, 711)

The decision appealed from is clearly inconsistent with all of the above cases. It is important that this Court accept

jurisdiction of this appeal in order to resolve the obvious conflict of judicial opinion that has now arisen by virtue of this decision concerning the implementation date of the federal law requiring states to reimburse facilities on a reasonable cost-related basis. Otherwise, New York will be permitted to avoid compliance with reasonable cost-related reimbursement standards while other states will be required to comply with the very same standards.

(iv) *The State Court Decision Appealed From Ignored The Fact That The Challenged State Statutes and Regulations Had Never Received Prior Federal Approval And Had, In Fact, Been Specifically Disapproved By HEW*

Among the other reasons advanced by the Court below for rejecting Appellants' attack on the constitutionality of the State's new reimbursement regulations was that Appellants had not shown that the regulations violated Federal reasonable cost-related principles. 44 N.Y. 2d at 755. This was a highly disingenuous holding since the Court knew of HEW's July 12, 1977 letter (Appendix "K") to the State which specifically disapproved the regulations on that very basis. Appellants had referred to this letter in their Brief to the New York Court of Appeals. The Court simply ignored it.

Moreover, the Court of Appeals improperly shifted to Appellants the burden of showing that the regulations failed to satisfy the Federal reasonable cost-related test when, in fact, the burden was on the State, in the first instance, to satisfy Federal officials as to the adequacy of the regulations. 42 USC §1396a(a)(13)(E); 42 CFR 450.30(a)(3). Appellants merely contended that the State's new reimbursement regulations would be unconstitutional if implemented without necessary prior Federal approval. *Hospital Association of New York v. Toia,* (USDC, SDNY, decided July 30, 1976; Docket No. 76 Civ. 2027; Medicare and Medicaid Guide [CCH], ¶27, 941). No such approval was, of

course, ever given and, in fact, such approval was, as previously stated, specifically denied (Appendix "K").

Moreover, it is remarkable that in one breath the Court below could say, as it did, that New York's Laws had been "altered from 'cost' factors" (44 N.Y. 2d 755) and then, in the next breath, say that Appellants "have not shown" that the regulations were not reasonably cost-related. *Id.*

The original trial court was troubled by the challenged statute and ruled it unconstitutional; even the State's Appellate Division, although it resolved the issue against Appellants, was troubled enough to write lengthy majority and dissenting opinions; even Governor Carey, in signing the bill into law, admitted that there were potentially serious problems with the legislation. 1976 N.Y. Laws (McKinney) at 2344. New York's Court of Appeals, however, blithely ignored many important questions and issues in its cursory treatment of this case.

To summarize, if the ruling below is allowed to stand, New York State will be permitted to apply the challenged statute and reimbursement regulations for 1976 and 1977, nothwithstanding the fact that they were specifically and unequivocally disapproved by HEW and even though federal law clearly requires that prior approval from HEW is necessary before such reimbursement regulations can be implemented.

(v) *The Challenged Legislation's Retroactive Reduction Of Rates, After Services Rendered By Appellants Were Already Paid For By The State At Previous Higher Rates, Unconstitutionally Impaired Appellants' Contractual Rights And Deprived Them Of Their Property Without Just Compensation Or Due Process of Law*

Aside from the serious Supremacy Clause questions raised by the legislation challenged in this appeal, there are, as well, other problems raised by the retroactive application of New York's reimbursement regulations, which have caused Appellants and the class they represent to be divested of over $34.3 million in payments for services rendered between January 1, 1976 and November 1, 1976, when the regulations were retroactively applied. Appellants have contended throughout this litigation that this retroactive application impaired their contractual rights arising out of their provider agreements entered into with the State.

This Court, in two recent decisions invalidating State statutes, has made it absolutely clear that the Contracts Clause retains its viability in modern constitutional jurisprudence. *United States Trust Co. of New York v. New Jersey*, 431 US 1 (1977); *Allied Structural Steel Co. v. Spannaus*, ____ U.S. ____, 98 S. Ct. 2716 (1978). Both cases dealt with situations where retroactive State legislation divested parties to certain contracts of important rights given to them under those contracts. *United States Trust Co., supra*, is especially significant because there, as here, the other party which benefited from the statutory retroactive modification, was the State itself. This Court made it clear that any attempts by a state to legislatively repudiate its own contractual debts or obligations would be subject to special scrutiny under the Contracts Clause. 431 US at 22-23.

Both *United States Trust* and *Spannaus, supra*, made it clear that while states may, under some limited circumstances, enact legislation modifying the terms of a contract, such circumstances

are limited to instances where the contractual right impaired is merely deferred, not extinguished (*Home Building and Loan Assn. v. Blaisdell,* 290 U.S. 398 [1934]); or where the right impaired is considered inconsequential (*El Paso v. Simmons,* 379 U.S. 497 [1965]); or where the sovereign powers of the State would otherwise be limited (*East New York Savings Bank v. Hahn,* 326 U.S. 230 [1945]). Here, however, none of those exceptions applies.

The State here simply repudiated its own financial contractual obligations with Appellants by retroactively adopting a statute and regulations which set up a different rate and then applied those rates retroactively to services already rendered and paid for at a higher rate.

The New York State Court of Appeals rationalized the State's action, however, by stating that Appellants' provider agreements did not "... establish rights to reimbursement under any specific rate or regulation." *Matter of Kaye v. Whalen,* 44 N.Y. 2d 754, 755. The provider agreements (Appendix "J"), however, specifically stated that services were being performed by Appellants "... in consideration of receiving payment for services provided to individuals receiving assistance under the New York State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act . .".

That Plan, as previously indicated, included the old Part 86 regulations, pursuant to which Appellants seek payment in this lawsuit. Those Part 86 regulations were part of existing New York State law on January 1, 1976. Moreover, 10 NYCRR §86.34 (*supra* at p. 11), a State regulation readopted after the enactment of the legislation challenged herein, stated that the old Part 86 reimbursement regulations were to remain in effect until the new reimbursement regulations were published pursuant to chapter 76 of the Laws of 1976. Later, however, when those new regulations were published, Appellees applied them retroactively, notwithstanding §86.34, *supra.*

That Appellants had a contractual right to rely on payment pursuant to the old Part 86 regulations is clear. Those regulations were part of New York Law at the time the Appellants' provider agreements with the State were entered into, and as noted above, those provider agreements explicitly incorporated by reference Part 86 regulations. This Court has consistently recognized that the laws existing at the time and making of a contract enter into and form a part of the contract as if they were expressly referred to or incorporated in its terms. *HomeBuilding and Loan Association v. Blaisdell,* 290 US 398, 429-430 (1934). "This principle assumes that contracting parties adopt the terms of their bargain in reliance on the law in effect at the time of the agreement." *U.S. Trust Co. of New York v. New Jersey,* 97 S. Ct. 1505, 1516, n. 17 (1977). Provider Agreements adopting a methodology for determining a rate of payment may not be retroactively modified by State law. *Briarcliff Haven, Inc. v. Department of Human Resources of the State of Georgia,* 403 F. Supp. 1355 (N.D. Ga., 1975). *Capital Convalescent Center v. State of Nevada,* 547 P. 2d 677 (1976).

The retroactive application of New York's statutes and regulations in this case poses serious Due Process questions as well. The Fifth Amendment to the United States Constitution, when read in conjunction with the Fourteenth Amendment, prohibits states from taking a person's property without just compensation or due process of law. It is well-recognized in New York State that nursing homes have a property right in payments already received from the State for services rendered in the Medicaid program. *White Plains Nursing Home v. Whalen,* 42 N.Y. 2d 838 (1977), cert. denied ____ U.S. ____ (1977). *Matter of Bradley v. Whalen,* 58 App. Div. 2d 664 (1977).

To retroactively take away such property rights, which vested when services were rendered and paid for by the State, seems to be a clear violation of the constitutional prohibitions embodied in the Fifth and Fourteenth Amendments.

Finally, there is a simple issue of fairness and justice. By virtue of the retroactive legislation attacked in this appeal, the State of New York has retroactively taken back from Appellants and the class they represent over $34.3 million in payments already paid to such facilities and which the facilities had no legal reason to suspect would be subject to subsequent recoupment. If the decision below is allowed to stand, no contract with the State of New York will ever be worthwhile since, at any time, the State could thereafter enact legislation retroactively rescinding the terms thereof to its own advantage. No State should be allowed to induce a party into a contract and then later, after that party has performed services in good faith in reliance on the terms of the contract, change the terms to suit its own advantage. The Contracts Clause of the Constitution was designed to prevent just such an evil.

CONCLUSION

Substantial federal questions affecting matters of an important national concern have been raised in this appeal. Several other courts and jurisdictions have, on the same issues, rendered decisions contrary to the one herein appealed from. In addition, elementary questions of justice and fairness are raised by the State's retroactive recoupment of over $34.3 million. For all of these reasons, this Court should note probable jurisdiction of this appeal.

Respectfully submitted,

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August, 1978

Appendices

APPENDIX A

Memorandum Decision of the New York State Court of Appeals

STATE OF NEW YORK
COURT OF APPEALS

No. 164

In the Matter of

Leslie Kaye, et al.,

Appellants,

vs.

Robert P. Whalen, as Commissioner of Health of the State of New York, et al.,

Respondents.

MEMORANDUM

This memorandum is uncorrected and subject to revision before publication in the New York Reports.

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(164) Cornelius D. Murray & Lewis A. Aronowitz, Albany, for appellants.

Louis J. Lefkowitz, Attorney-General (Arthur Patane, Ruth K. Toch & Edward J. Kelly of counsel) for respondents.

MEMORANDUM:

The order of the Appellate Division should be affirmed.

Retroactive application of the rates and regulations promulgated by the Commissioner in October of 1976 was expressly authorized by statute (Public Health Law § 2807 [2] [e], L

1976, ch. 76 § 11). We find no merit in the appellants' argument that retroactive application of the rates impaired existing contract rights in view of the fact that the provider agreement does not establish rights to reimbursement under any specific rate or regulation. In addition, with the enactment of Public Health Law § 2808 [1], prior to 1976, the appellants were put on notice that the standard of reimbursement had been altered from "cost" factors (Public Health Law § 2807 [3]) to consideration of *inter alia* "the operation and program management of the facility, as well as the quality of patient care provided by the facility." They were also notified by letter that the amounts received for services provided in 1976 should be considered tentative and subject to adjustment upon adoption of new rates and regulations.

We reject petitioners' contention that the rates set by the Commission in October, 1976 were invalid for failure to have received HEW approval under the provisions of U.S. Code Tit 42 § 1396a [A] [13] [E]. In the first instance it is noted that petitioners have not shown that the October rates violated the substantive standards established by the federal statute which merely requires reimbursement rates to be set "on a reasonable cost related basis". Furthermore it is made clear by the letter dated September 30, 1976 from the Associate Regional Commission of HEW to the State Commissioner that HEW would not be able to implement this new requirement or to grant the contemplated approval except for rates effective after January 1, 1977.

• • •

Order affirmed, with costs, in a memorandum. All concur.

Decided April 25, 1978.

APPENDIX B

Decision of the New York State Supreme Court, Appellate Division — Third Department.

STATE OF NEW YORK – SUPREME COURT
APPELLATE DIVISION – THIRD DEPARTMENT

In the Matter of LESLIE KAYE et al., on Behalf of Themselves and All Others Similarly Situated,

Respondents,

—against—

ROBERT P. WHALEN, as Commissioner of Health, et al.,

Appellants.

Argued, November 23, 1976.

Before: HON. T. PAUL KANE, *Justice Presiding,* HON. A. FRANKLIN MAHONEY, HON. ROBERT G. MAIN, HON. JOHN L. LARKIN, HON. J. CLARENCE HERLIHY, *Associate Justices.*

APPEAL from a judgment of the Supreme Court at Special Term (Ellis J. Staley, Jr., J.), entered September 16, 1976 in Albany County, which granted petitioners' application in a proceeding pursuant to CPLR article 78.

LOUIS J. LEFKOWITZ, Attorney-General (Arthur Patane and Ruth Kessler Toch of counsel), for appellants, The Capitol, Albany, New York 12224.

O'CONNELL & ARONOWITZ, P.C. (Cornelius D. Murray of counsel), for respondents, 100 State Street, Albany, New York 12207.

OPINION FOR REVERSAL

SUPREME COURT – APPELLATE DIVISION
THIRD JUDICIAL DEPARTMENT

February 14, 1977. 29801

In the Matter of LESLIE KAYE et al., on Behalf of Themselves and All Others Similarly Situated,

Respondents,

v.

ROBERT P. WHALEN, as Commissioner of Health, et al.,

Appellants.

Judgment reversed, on the law and the facts, and petition dismissed, without costs. Upon service of a copy of the order to be entered hereon together with notice of entry, the preliminary injunction heretofore granted by order of this court, entered November 19, 1976, is vacated.

Opinion per MAHONEY, J.

LARKIN and HERLIHY, JJ., concur; KANE, J.P., and MAIN, J., dissent and vote to affirm in an opinion by KANE, J.P.

MAHONEY, J.

The Medicaid Program (Subchapter XIX of the Social Security Act, U.S. Code Tit. 42, § 1396 *et seq.*) makes available funds, to be supplemented by State contributions, to pay for the medical care of those whose means fall below certain financial standards. The federal funds are available to those States which submit a plan for administering the funds acceptable to the Secretary of Health, Education and Welfare (U.S. Code tit. 42, §1396). The statute imposes myriad requirements as to what constitutes an

acceptable plan (U.S. Code tit. 42, §1396a), but does not purport to set the specific rates at which those providing the medical services are to be reimbursed. That duty is left, within the confines of the requirements of section 1396a, to the States.

The New York State Legislature charges the respondent Commissioner of Health with the responsibility of setting the rate at which the petitioners, nursing home owners, are reimbursed for the care they provide Medicaid beneficiaries. Until August, 1975 the statutory standard by which the Commissioner was directed to set rates was subdivision 3 of section 2807 of the Public Health Law, which required that the rates be "reasonably related to the costs of efficient production of such service." The subsection goes on to impose a few specific standards, such as requiring the Commissioner to consider "geographical differentials in the elements of cost" and to "exclude costs for research." Subdivision 4 of section 2807 (L. 1974, ch. 682, § 1) directs the Commissioner to notify each nursing home of new rates 60 days before the fiscal year for which the rates are to be effective.

The Commissioner promulgated regulations, as he was required to do (Public Health Law, § 2803, subd. [2], par. [b]), stating in detail the criteria by which he would set the reimbursement rates (10 NYCRR, Part 86). The regulations also specified that the rates would be set for calendar year periods (10 NYCRR 86-1.10). Thus, it appears from both the regulations (10 NYCRR 86-1.10) and the statute (Public Health Law, § 2807, subd. [4]) that new rates would be established before November 1 each year, to become effective the following January 1 and remain in effect for one year.

This case concerns the legality of two actions by the Commissioner. In November, 1975 he adopted as tentative rates for 1976 the 1975 reimbursement rates, rather than generating new

rates based on the criteria set forth in the then-existing Department regulations. In October, 1976 he established new rates and made them retroactive to January 1, 1976, thereby supplanting the tentative rates set the previous November. Petitioners, nursing home owners, brought this article 78 proceeding in February, 1976 to invalidate the tentative rates of November, 1975 and to force the Commissioner to set 1976 rates consistent with his 1975 regulations. In September, 1976 Special Term granted the requested relief and further enjoined the Commissioner from changing his method of computing rates without first securing the approval of the U.S. Department of HEW. Although the Commissioner's rate-setting action of October, 1976 occurred after Special Term's judgment, the substance of the post-judgment rate-setting is not disputed and may be considered here without the need to remand. We accept the truth of petitioners' uncontested allegation that both the November, 1975 and October, 1976 rates for 1976 are generally lower than the 1976 rates would have been had they been set in keeping with the regulations.

Petitioners' first ground for relief is that in each instance the Commissioner acted without statutory authorization. With respect to the November, 1975 tentative rates, it is true that the then-existing regulations stated criteria, established under the standards of subdivision 3 of section 2807 of the Public Health Law whereby rates would be set for each new calendar year. Absent further legislative action before January 1, 1976, perhaps it would be fair to conclude that the Commissioner was bound either to promulgate new regulations in the manner required by law (see N.Y. Const., art. IV, § 8; Executive Law, §§ 102, 103, 105) or to mechanically generate new rates conforming to the

extant regulations. (But see, State Administrative Procedure Act, § 202, subd. 1[d] [eff. Sept. 1, 1976].*

However, further legislative action had been taken, with the addition of section 2808 (L. 1975, ch. 649, § 7, and ch. 650, § 2 [eff. Aug. 6, 1975]), which provided, *inter alia*, that:

> 1. a. The Commissioner shall promulgate interim regulations to expire no later than the thirty-first day of December, nineteen hundred seventy-six, that will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with regulations promulgated under the provisions of title eighteen of the federal social security act, by which payment for costs incurred by a residential health care facility for a quantity and quality of supplies or services necessary for the proper operation of a residential health care facility *shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services.* [Emphasis supplied.]

Paragraph (b) of subdivision 1 goes on to direct promulgation of interim regulations regarding real property costs. Section 2 mandates that certain costs, such as political or lobbying payments, certain types of advertising expenses, and fines should not be added in to determine 1976 rates.

Section 202 of the SAPA makes explicit after September 1, 1976 what previously may have been implicit in the nature of the function of administrative agencies, to wit " * * if the agency finds that immediate adoption * * * or repeal of a rule is necessary for * * * the public health, safety, or general welfare, and that observation of the requirements of notice and public hearing would be contrary to the public interest, the agency may dispense with all or part of such requirements and adopt the rule * * * or repeal as an emergency measure".

Although certain aspects of section 2808, such as the provision disallowing consideration of fines paid, may have been implicitly part of the pre-existing statutory standards of subdivision (3) of section 2807 (under which the regulations existing in 1975 were promulgated), there were certainly some significant changes made by section 2808. The controlling standard for rate determination in the subdivision (3) of section 2807 was that rates be "reasonably related to the costs of efficient production of such service." The general standard added August 6, 1975 by section 2808, as noted above, was that rates "shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or service." Moreover, section 2808 incorporated new, detailed standards via regulations under the federal social securities act.

For the Commissioner to ignore the new standards of section 2808 by simply generating new rates through his old regulations would have been clearly in conflict with the Legislature's will. Surely, the Legislature cannot be encumbered, absent constitutional constraints, by the administrative delays involved in promulgating new regulations. The purpose of regulations is to carry out statutory directives. It is true section 2808 required promulgation of interim regulations, but apparently the Commissioner had insufficient time between August 6 and November 1, 1975 to do so. It was better to carry out the substantive standards of section 2808 by tentatively continuing (without interim regulations) the 1975 rate, believing it to closely approximate the rate mandated by section 2808, than to set a new rate on the basis of regulations promulgated under a statutory standard (§ 2807, subd. [3]) no longer in effect. Petitioners have not even attempted to prove that the interim rate set in 1975 was inconsistent with the standard of section 2808.

In any event, the Commissioner's November, 1975 action was mooted by the 1976 rates set on October 22, 1976. These rates, set pursuant to new regulations published contemporaneously with the new rates, are retroactive to January 1, 1976 and therefore will fully supplant the tentative rates. Retroactive application to January 1, 1976 of rates set pursuant to section 2808 (rather than the more generous standard of section 2807, subd. 3) was explicitly authorized by the addition of paragraph (e) of subdivision 2 of section 2807 . . .

> During the period beginning January first, nineteen hundred seventy-six, and ending March thirty-first, nineteen hundred seventy-seven, the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities without regard to the provisions of subdivision three of this section. The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph * * *.
>
> (L. 1976, ch. 76, §11 [enacted March 30, 1976].)

Petitioners contend that no retroactive application was intended since section 18 of chapter 76 of the Laws of 1976 stated "[t]his act shall apply to care, services, and supplies furnished on and after the applicable effective date." This presents no ambiguity since section 18 sets several different effective dates for different portions of chapter 76 and states that section 11 (i.e., the portion adding section 2807, subd. 2, par. [e]) "shall be deemed to have been in full force and effect on and after the first day of January, nineteen hundred seventy-six."

Aside from any question of statutory authorization, petitioners contend the Commissioner's actions impaired contractual rights. The only contract they claim rights under is the form agreement between each of them and the State, entitled "New York State Department of Social Services Medicaid Provider Agreement (Full Compliance)". By the terms of this agreement the particular nursing home is certified for 12 months as in full compliance with the federal standards for a "Skilled Nursing Home" (45 C.F.R., Part 249) and "in consideration of receiving payments for services provided to individuals receiving assistance under the New York State Plan * * * pursuant to [Medicaid] hereby agrees" to keep certain records and to "not discriminate as to source of payment in admission and retention of patients * * *".

Petitioners argue that this agreement incorporates all details of the New York State Plan, which, in order to obtain federal medicaid funds, was submitted for HEW approval. Since that Plan included the Commissioner's 1975 regulations for generating reimbursement rates, there is an implicit promise by the State to the various participating nursing homes that payment would be made at rates consistent with those regulations. This interpretation does not follow from the contract language. The reference to the "New York State Plan" seems intended only to identify exactly which patients the contract covers. Petitioners allege no extrinsic facts which lead to a different construction. Although there may be an implicit promise by the State to retain the reimbursement rate at some minimum level, the contract is insufficiently precise to support petitioners' claim to a rate above that which the statute now authorizes; the statutory standard being an amount not to exceed that "which would be paid in the normal course of business by a prudent buyer of such supplies or services" (Public Health Law, §2808, subd. 1, par. [a]; L. 1975, ch. 649, § 7). The

Supreme Court of Minnesota, on facts very close to those herein, has similarly held a plaintiff nursing home which executed a federal "provider agreement" had no contractual right to any particular level of payment (*LaCrescent Constant Care Center, Inc. v. State Department of Public Welfare*, 301 Minn. 229, 222 N.W. 2d 87 [1974]).

Petitioners next contend that the respondent violated U.S. Code tit. 42, § 1396a [a] [13] [E] in not obtaining prior HEW approval for the new October, 1976 rates and regulations. Section 1396a imposes various requirements on the State plans for administering Medicaid funds. Subdivision (a) (13) (E) requires such plans to provide —

> effective July 1, 1976, for payment of the skilled nursing facility * * * services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods *approved and verified by the Secretary* * * *. [Emphasis supplied.]

This statute was the basis for Special Term's order to respondent to continue reimbursement to petitioners at a rate consistent with the 1975 regulation until approval for new rate-making procedures is obtained from HEW.

Assuming petitioners have standing to enforce the approval requirement, the first issue is whether this statute, effective July 1, 1976, applies to a new rate-making procedure implemented in October, 1976 to be retroactive to January 1, 1976. The Department of HEW promulgated on July 1, 1976 a regulation pursuant to section 1396a (a) (13) (E) which exactly repeats the statutory language quoted above (45 C.F.R. 250.30 [a] [3], added by 41 Fed. Reg. 27305 [1976]). Respondent Com-

missioner has appended to his brief a letter dated September 30, 1976 from the Associate Regional Commissioner of HEW responding to a question posed by the New York Department of Social Services as to whether "there are any restrictions in terms of statutory or regulatory requirements to New York adopting a revised rate for [Nursing Homes] on a retroactive basis." The Associate Commissioner answered, *inter alia*, that

> Prior to the publication of the July 1, 1976 regulation, there was no specific methodology of reimbursement required for [Nursing Homes] in the [Medicaid] State plan. The regulations * * * provided that the State established [*sic*] schedules of charges which were consistent with the intent that upper limits did not exceed amounts paid under Title XVIII for similar services.
>
> * * * [O]ur regulations have not previously required HEW approval of the reimbursement methodology developed by the States for [Nursing Homes] * * *. Therefore, revisions to rates for periods prior to the implementation of 250.30 [a] [3], [December 31, 1976] are not contrary to Federal regulations insofar as they meet the test of not exceeding amounts paid under Title XVIII.

He further stated that under the July 1, 1976 regulation (45 C.F.R. 250.30[a][3]), which implements the statutory provision (§ 1396a[a][13][E]) upon which petitioners rely, the

> [a]pproval of cost-finding methods takes place when State Plan amendments are submitted. The [revisions] to the [Medicaid] State Plan are due in the Regional Office by December 31, 1976.

Petitioners refer to this letter in their brief and do not challenge the propriety of this court's consideration of it.

The letter indicates that the HEW mechanism for approving changes in rate-making procedures was established by HEW to consider only changes effective after January 1, 1977. Therefore, it was not possible for the respondent Commissioner to obtain approval for the October, 1976 rates. Although section 1396a (a)(13)(E) on its face was to be effective July 1, 1976, it is impossible for this court to find that HEW, in waiting until January 1, 1977 to fully implement the approval mechanism, violated the statutory directive. This record contains no evidence of the exigencies faced by HEW in administering the Medicaid Plans of the several states.

Furthermore, even if a federal approval mechanism had been available, the respondent's failure to obtain approval for his October, 1976 rates would not justify the relief requested. Petitioners have not shown the October rates violate the substantive standard of section 1396a (a)(13)(E), which merely requires reimbursement rates to be set "on a reasonable cost related basis."

Finally, petitioners claim vested rights in the monies they have actually received during 1976 under the tentative rates set in November, 1975. They urge that this court's decision in *White Plains Nursing Home* v. *Whalen* (53 A D 2d 926) precludes the respondent from recouping the difference between the tentative rates and the October, 1976 rates he proposes to make retroactive to January 1, 1976.

Petitioners here were notified by November 1, 1975 of their individual tentative rates and that final 1976 rates reflecting "upward or downward revision will be promulgated as soon as possible" (Dept. of Health Mem., 75-159). In the *White Plains Nursing Home* case the Commissioner had set a reimbursement rate for 1975 for the petitioner White Plains Nursing Home with no indication that the rate was subject to change during 1975.

We held that since petitioner White Plains Nursing Home performed services in reliance on the apparently final 1975 rate, it had a property right in such rate which the Commissioner could not impair without a hearing.

No such reasonable reliance was possible by petitioners herein. They were free to refuse Medicaid patients if the reimbursements rate was below the fee they demanded from the public generally. The petitioners cite no statute requiring them to accept patients at the Medicaid rate, and the only regulation which arguably imposes such an obligation is 10 NYCRR 730.2 — "[the operator shall] not discriminate because of race, color, blindness or *sponsorship* in admission, retention and care of patients." (Emphasis supplied.) There is nothing in this language which would preclude a nursing home from excluding any prospective patient who does not pay the established fee charged all patients. Neither does anything in the provider agreement referred to earlier, nor the general arrangement between the State and petitioners, imply such an obligation (cf. *Matter of Sigety* v. *Ingraham*, 29 N Y 2d 110, 115).

Since the petition will be dismissed, it is not necessary to decide if class relief, granted by Special Term, would have been appropriate.

The judgment should be reversed, on the law and the facts, and the petition dismissed, without costs. Upon service of a copy of the order to be entered hereon together with notice of entry, the preliminary injunction heretofore granted by order of this court, entered November 19, 1976, should be vacated.

KANE, J. P. (dissenting).

Although diplomatically called the establishment of a "tentative" rate by the majority, in plain words and fact the respondents simply froze 1976 Medicaid reimbursement rates at existing 1975 levels. This the majority says they were permitted to do by section 2808 of the Public Health Law. We disagree. It also concludes that chapter 76 of the Laws of 1976 authorized their later action in fixing new rates for 1976 retroactively and that such action neither impaired any contractual rights nor offended relevant Federal statutes and regulations. Again we disagree. The judgment of Special Term should be affirmed with certain modifications.

We believe that this proceeding was properly maintained pursuant to CPLR article 78. Petitioners' basic complaint is that respondents failed to perform their statutory duties and, in fact, exceeded their authority. While a determination fixing rates is involved, the petition does not ask for certiorari review of a matter ordinarily deemed a legislative act; it seeks redress in the classic nature of prohibition and mandamus to restrain an allegedly unauthorized activity and to compel compliance with those duties. In any event, we would not hesitate to treat the present litigation as an action for declaratory judgment (cf. *Matter of Lakeland Water Dist.* v. *Onondaga Water Auth.*, 24 N Y 2d 400; *Matter of White Plains Nursing Home* v. *Whalen*, 53 A D 2d 926; *Matter of Severino* v. *Ingraham*, 45 A D 2d 564). However, petitioners did not obtain an order allowing them to maintain this proceeding as a class action (CPLR 902). Since Governmental operations are involved and subsequent petitioners would be adequately protected under the principles of *stare decisis*, the judgment of Special Term should be modified by deleting references to class relief (*Matter of Jones* v. *Berman*, 35 N Y 2d 42, 57).

Turning to the substantive aspects of this proceeding, it should be recalled that petitioners first questioned the lawfulness of the rate freeze in February of 1976. In answer to their petition, it was alleged that section 2808 of the Public Health Law supplanted all or a portion of section 2807 thereof and that certain fiscal considerations and statutory uncertainty made it necessary to approve "interim" rates. An affidavit of the respondent Commissioner of Health expanded on these justifications. The fiscal considerations were said to be the serious financial plight of the City of New York and its resulting impact on the budget of the State. The supposed statutory uncertainty was founded on the expected passage of a proposed Medicaid revision bill which would have frozen reimbursement rates from January 1, 1976 through March 31, 1977. The former reason undoubtedly supplied motivation to conserve State resources, but it hardly conferred authority on respondents to single out residential health care facilities as a target for effecting such savings. The latter explanation was completely worthless. In addition to the fact that the Legislature did not bring their prediction into reality, respondents were obviously not entitled to anticipate future legislation but were bound to follow the statutes then in existence until they were changed.

In apparent recognition of the inherent weakness of these arguments, the majority seizes upon respondents' reference to section 2808 of the Public Health Law and maintains that it set a new standard for the establishment of Medicaid reimbursement rates which authorized the freeze initially imposed. This will surely come as welcome news to respondents, particularly since they never claimed that statute possessed such a broad effect before Special Term or in their brief and argument in this court. The aforementioned affidavit of the Commissioner of Health merely stated that section 2808 "* * * appears to

supplant all, or at least a portion of the traditional rate setting provisions of [s]ection 2807 * * *" and concluded in a self-serving fashion that "* * * [u]ntil this issue is resolved it would not be prudent to go forward with 1976 reimbursement." If this represents solid reliance on some newly found standard, it is a remarkably timid manner of expressing it. In our view that statute simply directed the promulgation of interim regulations, exactly as it was worded, and the Commissioner of Health apparently so understood it for he did adopt a new regulation pursuant thereto, *before* the rate freeze was imposed, which reaffirmed and continued the effectiveness of his former regulations (see former 10 NYCRR 86.34, eff. Oct. 14, 1975). Far from establishing any new standard, section 2808 required only that certain interim regulations be consistent with Federal regulations on the same subject. The standard contained in subdivision (3) of section 2807 was not repealed, as one might expect had the Legislature truly intended section 2808 to take its place, but remained intact and partially survived amendments made by chapter 76 of the Laws of 1976. Furthermore, even if what a "prudent buyer" would pay constitutes some type of standard, we fail to appreciate how it materially differs from the "costs of efficient production" language. Not often in the normal course of business may a careful buyer obtain something for less than the cost of its efficient production; he certainly cannot do so repeatedly for very long.

Finally, nowhere in the record or briefs before us have respondents even suggested that the frozen rates "closely approximated" the rates mandated by section 2808 as stated by the majority. Petitioners have not attempted to prove that the "tentative" rates were inconsistent with section 2808 because, until now, they were never given any reason to believe that statute might have played a part in respondents' decision to

freeze those rates. The issue is not whether proper 1976 rates would be higher or lower than those in use during 1975, but whether respondents had authority to act as they did when they did. Nothing contained in section 2808 of the Public Health Law expressly or impliedly empowered respondents to set an interim or temporary rate and, pending the adoption of valid regulations thereunder, they were obliged to follow the statutes and regulations then in effect. Quite plainly they did not do so and, accordingly, we agree with Special Term that the rate freeze was illegal, null and void.

Our disagreement with the second conclusion of the majority stems from the interpretation we place on chapter 76 of the Laws of 1976. As a general rule, statutes are prospectively construed unless a clear legislative expression to the contrary appears (*Matter of Mulligan* v. *Murphy*, 14 N Y 2d 223; McKinney's Cons. Laws of N.Y., Book 1, Statutes, § 51). The majority finds such an expression in section 18 of that enactment whereby the amendments to subdivision 2 of section 2807 of the Public Health Law were deemed to have been in effect on and after January 1, 1976. However, the same section also provided that "* * * [t]his act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act * * *" (L. 1976. ch. 76, § 18). While residential health care facilities have no property rights in prospective reimbursement rates, it seems clear to us that they do possess an "interest" in receiving payment for services already rendered which would be "affected" by a retroactive application of the challenged legislation. The language of the enactment is at least ambiguous and, therefore, we would decline to give it retrospective effect.

Assuming, *arguendo*, that petitioners' rates were properly frozen and that the Legislature meant to permit the retroactive application of chapter 76 of the Laws of 1976, two questions must still be resolved; could retroactive application of new rates be constitutionally accomplished without impairing contractual rights and did the particular action of the respondents in October of 1976 avoid the infringement of such rights?

Petitioners would surely not object to a retroactive windfall and the first inquiry poses difficulty only when the retrospective rates are lower than those previously in effect. *La Crescent Constant Care Center, Inc.* v. *State Deptartment of Public Welfare* (301 Minn. 229, 222 N.W. 2d 87) supplies no answer when this occurs for there the petitioner was contending that its provider agreement had incorporated the State Plan and associated statutory standard so that it had an affirmative contractual right to a rate of reimbursement higher than was then being paid. No element of retroactivity was involved in that case. Here, however, petitioners are asserting that their provider agreements contain sufficient terms to serve as a defensive shield to a later reduction in those reimbursement rates and we agree. Residential health care facilities must execute provider agreements with the State as a precondition to participation in the Medicaid program (see, U.S. Code, tit. 42, § 1396a [a] [27]) and, having done so, the fact that no specific payment rates are set forth does not mean that a contractual accord with the State has not been achieved. Mention of the State Plan is obviously a shorthand device used to signify the contractual arrangement chosen by the parties for determining the method and amount of payment to be made for services rendered. We do not wish to imply that a provider agreement may never be altered through some prospective change in the State Plan, but no matter how the Legislature might validly suspend or change the obligations

thereby created (see, *Home Building & Loan Assn.* v. *Blaisdell*, 290 U.S. 398; *Matter of Department of Bldgs. of City of N.Y. [Philco Realty Corp.]*, 14 N Y 2d 291), it could not have intended nor would it have been constitutionally permissible to abrogate them retroactively (see, *Flushing National Bank* v. *Municipal Assistance Corporation of the City of New York*, ___ N Y 2d ___ [Nov. 19, 1976]; *Patterson* v. *Carey*, 52 A D 2d 171).

The answer to the second question is somewhat complicated by the fact that respondents have conceded on this appeal that their action in October of 1976 will produce a reimbursement rate which is higher for some residential health care facilities than the initially frozen rate while for others it will be even lower. Its effect on these petitioners has not been developed in this record. Nevertheless, in our opinion petitioners' new 1976 rates may not be retroactively applied, following the foregoing analysis, if they are lower than the originally frozen rates. Parenthetically, this would also hold true if their new rates are lower than rates recalculated according to the statutes and regulations in effect on November 1, 1975, but we are still assuming that the primary freeze was valid and that chapter 76 of the Laws of 1976 was intended to be retroactively applied.

The majority discovers no necessity for petitioners to accept Medicaid patients and reasons that respondents' notification that the tentative reimbursement rates might be adjusted downward eliminated the need to accord them a hearing before recouping any difference between their frozen rates and the new rates. Although we do not think it necessary to presently decide whether residential health care facilities must accept Medicaid patients, these petitioners have alleged that they are required to do so and respondents have "admitted" that in their answer. The parties have thus foreclosed review of that issue in this proceeding and, for whatever their legal worth, 10 NYCRR 730.2

and the language of the provider agreements tend to support their stipulation. In any event, we are not actually concerned with whether the proposed recoupment works a deprivation of property (cf. *Matter of Sigety* v. *Ingraham*, 29 N Y 2d 110, 115), but whether it causes an impairment of contractual obligations. That is would most certainly do and no description of the original rate as being "tentative" or a subsequent hearing could cure that infirmity. Of course, absent the instant stipulation and provider agreements we would then face the situation addressed by the majority. If that were the case, we still fail to perceive how vested property rights in the form of payments made for services already rendered can be made to disappear according to the label applied to those payments in the first instance (*Matter of White Plains Nursing Home* v. *Whalen, supra*).

Lastly, our views obviate the necessity of considering the entire scope of petitioners' claim that the reimbursement freeze and retroactive application of new rates conflicts with certain Federal statutes and regulations (see, U.S. Code, tit., 42, § 1396a [a][13][E] and CFR 250.30 [a][3]). Special Term properly decided this proceeding on the basis of New York law and adequately protected petitioners by directing the recomputation of 1976 rates. The additional injunctive relief granted was unnecessary and its judgment should be further modified accordingly. However, were it not for our declaration concerning the impermissibility of applying chapter 76 of the Laws of 1976 retroactively, we would be inclined to agree with petitioners on this point (see, *Hospital Association of New York State Inc.* v. *Toia*, ___ F. Supp. ___ [Nov. 5, 1976, No. 76 Civ. 2027]; *Catholic Med. Center* v. *Rockefeller*, 305 F. Supp. 1268, affd. 430 F. 2d 1297, app. dsmd. 400 U.S. 931). The opposite interpretation placed upon the HEW *regulation* by an administrator is not impressive when the *statute* seems to require his superior's

approval and verification of cost-finding methods after July 1, 1976.

To recapitulate our position, although class action and injunctive relief were either unwarranted or unnecessary, respondents undertook the rate freeze without lawful authority. They should recalculate those rates in accordance with the statutes and regulations in effect on November 1, 1975 and make appropriate payments to petitioners if their recalculated rates prove to be higher than their frozen rates. Chapter 76 of the Laws of 1976 may not be utilized retroactively, but we have no reason to question the propriety or future application of rates established in conformity therewith. If retrospective application of that enactment were legally possible, the rates thereunder for such a period could not be lower than petitioners' recalculated rates and if the recalculation were itself unnecessary, the rates thereunder could not then be lower than those originally frozen.

The judgment of Special Term should be modified as indicated and affirmed.

APPENDIX C

Decision of New York State Supreme Court, Albany County Special Term.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

LESLIE KAYE, BARUCH GLOBERMAN, and SOL MALLOW, as Operators of the SANS SOUCI NURSING HOME; EMMANUEL BIRNBAUM and DESDEMONA JONES, as Operators of the FLELDSTON LODGE NURSING HOME; AND THE NEW YORK STATE HEALTH FACILITIES ASSOCIATION, a New York not-for-profit membership corporation, suing on behalf of its member licensed nursing homes and health-related facilities located within the State of New York,

Petitioners,

against

ROBERT P. WHALEN, as Commissioner of Health of The State of New York, and PETER C. GOLDMARK, as Director of the Budget of the State of New York,

Respondents.

For a Judgment Pursuant to Article 78 of the Civil Practice Law and Rules

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Supreme Court, Albany County Special Term, February 27, 1976 Calendar #16

JUSTICE ELLIS J. STALEY, JR., PRESIDING.

APPEARANCES: O'Connell and Aronowitz, P.C., *Attorneys for Petitioners,* 100 State Street, Albany, New York 12207. Louis J. Lefkowitz, *Attorney General of the State of New York,* The Capitol, Albany, New York 12224; Arthur A. Patane, Esq. *of Counsel.*

This is a proceeding pursuant to CPLR, article 78, for a judgment compelling the respondents to establish medical reimbursement rates in accordance with section 2807 of the Public Health Law, and the regulations promulgated by the Commissioner of Health, and to apply such rates retroactively to January 1, 1976.

Petitioners represent, as a class, all nursing homes and health related facilities in the State of New York participating in the Medicaid Program, which program is a joint Federal-State grant-in-aid program with the Federal government contributing 50 per cent of the funds, the State 25 per cent and the county 25 per cent. The Federal funds are distributed to the State where they are combined with funds appropriated by the State and its subdivisions. These funds are then paid by the State to the nursing homes and health related facilities rendering services to eligible Medicaid recipients. In New York State, the payments are made pursuant to rates established by the Commissioner of Health pursuant to section 2807 of the Public Health Law, which statute, in addition to setting forth certain factors which the Commissioner is to take into consideration in establishing rates, provides that "The Commissioner shall notify each hospital and health related service of its approved rate at least 60 days prior to the fiscal year for which the rate is to become effective."

In determining the rates, the Commissioner is also required by section 2802(2) of the Public Health Law, effective August 6, 1975, to exclude certain enumerated costs. The State Hospital Review and Planning Council is directed by section 2803(2) of the Public Health Law to adopt and amend rules and regulations subject to the approval of the Commissioner, to effectuate the provisions and purposes of article 28 of the Public Health Law including, but not limited to, the establishment by the department of schedules of rates, payments, reimbursements, grants

and other charges for hospital, health related services, and home health services as provided in section 2807.

Section 2808 of the Public Health Law, charges the Commissioner with the responsibility of promulgating interim regulations to expire no later than December 31, 1976 that will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility, and to promulgate interim regulations regarding real property costs to expire on the same date which shall be applicable to all residential health care facilities. By definition, the facilities operated by the petitioners are residential health care facilities. (Public Health Law, § 2801[3].)

The regulations provided to be promulgated by the statutes are to be found in 10 NYCRR, Part 86. For the most part, the regulations were amended and filed October 14, 1975, effective October 14, 1975. The new regulations for the most part do not affect residential health care facilities, pursuant to 10 NYCRR, 86.1 which excepts residential health care facilities from the definition of the term medical facility. Section 86.34 entitled Interim; rules for residential health care facilities, provides as follows: "For the purposes of reporting and rate certification for residential health care facilities, the provisions of this part, in effect on October 8, 1975, shall remain in effect for an interim period until regulations have been promulgated pursuant to sections 2807 and 2808 of the Public Health Law. The provisions of sections 86.15 (b) (4), 86.17 (a) and (b), and 86.21 (k) of this part, filed with the Secretary of State on November 26, 1975, apply to residential health care facilities as of said date."

The provisions of section 86.10 of the regulations in effect on October 8, 1975, are as follows:

> "Certification of reimbursement rates of payment by governmental agencies will be for a 12-month calendar year period. Certification of reimbursement rates by article IX-C forporations will be for the periods specified in the reimbursement formula approved by the Commissioner of Health."

By their petition, the petitioners assert that, in establishing the 1976 rates, the respondent Commissioner did not comply with the Statutory and regulatory procedures for calculating reimbursement rates, and simply froze the 1975 reimbursement rates. This contention is based upon the following factual allegations: On October 31, 1975, Hospital Memorandum, series 75-159 was issued stating that "each hospital, nursing home, health related facility, treatment or diagnostic center and home health agency has been directly notified of its Medicaid reimbursement rates for the period January 1, 1976 through December 31, 1976. The individual rates for each health facility were developed on an interim basis. New legislation concerning 1976 reimbursement, and still unresolved aspects of Part 86 of the Commissioner's rules have made it impossible to promulgate final health facility rates at this time." The memorandum further stated that final rates reflecting either upward or downward revisions will be promulgated as soon as possible. The rates established were reaffirmed by Hospital Memorandums 76-6 and 76-7 dated January 9, 1976 wherein it was stated that "It is still not possible to promulgate final rates, so the rate schedules will be used to permit billings at the interim level."

The 1976 reimbursements rates established by the Commissioner are, according to petitioners, in all cases identical to or lower than the 1975 rates for all members of the class, whereas they should have been increased by reason of (1) increased labor costs mandated by pre-existing negotiated contracts or increased labor costs consistent with labor costs in the relevant

geographical area, or increase in the Federal minimum wage; (2) higher allowable costs during the base period upon which 1976 rates would properly be calculated; (3) increases attributable to necessary additions to staff and services mandated by State and Federal regulations; (4) a projected cost increase factor which the Commissioner has calculated but not applied; and (5) other increased costs which would have been recognized had Part 86 of the Commissioner's Rules been followed.

The petitioners further contend that they and the other members of the class may not refuse to accept Medicaid patients. (State Hospital Code, § 730.2[1]) and that, unless they receive the Medicaid rates to which they are entitled by statute and regulation, they will be unable to provide the mandated level of services and care required by State and Federal regulations, thereby jeopardizing the health and safety of the patients, and thereby subjecting themselves to the severe penalties and fines amounting to as much as $1,000.00 per day pursuant to section 2803 (6) of the Public Health Law. The Medicaid population of these facilities are stated to be approximately 65 to 75 per cent.

The petitioners further contend that the actions of the respondents in establishing the 1976 Medicaid reimbursement rates at the 1975 level is illegal, arbitrary, capricious and unconstitutional.

As a second ground for relief, the petitioners assert that, although 10 NYCRR 86.17 provides for administrative appeals for redetermination of certified rates, the Commissioner will not entertain such appeals on the ground that they are interim rates, and they were not accompanied by rate calculation sheets. Evidence of this position is contained in a letter to the counsel for a member of the class dated November 24, 1975, signed by the Director of the Bureau of Health Care Reimbursement.

As a third ground for relief, the petitioners assert that any change in a State plan under the Medicaid Program effectuating a reduction of money payments requires the prior approval of the United States Secretary of Health, Education and Welfare, (42 USC, § 1396-a[c]) and respondents actions in establishing the 1976 rates without such approval jeopardizes the entire State Medicaid Program by inviting its termination for non-compliance with the Federal requirements.

As a fourth ground for relief the petitioners assert that under Federal law, State reimbursement for Medicaid must, after July 1, 1976, be made on a "reasonable cost related basis", (42 USC, § 1396-a[a][12[E]), and that the arbitrary and capricious rates set by respondents without regard to costs and stated to be applicable for the entire year violate the specific provisions of the Federal Law, thereby jeopardizing the entire Medicaid Program in the State, and inviting termination for noncompliance pursuant to 42 USC, § 1396(c).

The petitioners ask for a judgment (1) declaring the actions of the respondents in establishing the 1976 rates illegal null and void; (2) ordering the respondents to compute a reimbursement rate for each nursing home and health related facility for fiscal 1976 in accordance with the effective regulations and statutory requirements, and to apply such rates so computed retroactively to January 1, 1976; (3) enjoining respondents permanently from effectuating any amendments or changes in the method of reimbursement of nursing homes and health facilities in a manner not in compliance with the approved State Plan filed with the United States Department of Health, Education and Welfare, without the prior approval of the Secretary of Health, Education and Welfare; and (4) enjoining respondents from effectuating any amendments in the method of such reimbursement for any period subsequent to July 1, 1976 which is not

consistent with the reasonable cost related requirements of 42 USC, §1396-a (a) (E).

The respondents' answer consists of a general denial of the material allegations of the petition; an allegation that section 2808 of the Public Health Law supplants all or at least a portion of section 2807; an affirmative defense that fiscal conditions and statutory uncertainty made it necessary to certify and approve in interim rates which is not arbitrary and capricious or contrary to statute or regulation; and an affirmative defense that petitioners have failed to set forth facts entitling them to the relief sought or to any relief pursuant to CPLR, article 78.

An affidavit attached to the answer by the respondent Commissioner recognizes the requirements of section 2807(4) of the Public Health Law as to notification of reimbursement rates 60 days before the fiscal year in which they are to be used. The affidavit further states that the Commissioner requested approval from the Director of the Budget to establish interim rates for 1976 on October, 28, 1975, and that he received such approval based upon fiscal considerations and statutory approval. The affidavit then elaborates upon the financial plight of the City of New York, and the impact of the Medicaid Program upon the budget of the City of New York and of the State, and states that based upon the financial uncertainties facing both the City of New York and the State, it was neither prudent nor possible to develop the 1976 reimbursement rates for health care facilities without legislative budgetary guidance, which guidance was expected in a Medicaid bill anticipated to be passed by the Legislature by March 15, 1976. Reference is also made to section 2808 of the Public Health Law and its effect on rate setting provisions of sections 2807 and the anticipated Moreland Act Commission report which would probably recommend further statutory revisions.

However commendable and cogent the reasons advanced by the Commissioner for establishing interim rates may be, for the purposes of financial stability and integrity, it is clear that the Commissioner has not followed statutory directives and his own rules and regulations. While section 2808 has a certain impact on rates, it required him as of its effective date to promulgate "interim regulations", not interim rates, for residential health care facilities. The Commissioner was aware of this when he promulgated rule 86.34 quoted above as an interim rule. Nowhere in the appropriate statutes, or in the rules and regulations is there found any authority to depart from statutory proceudre or from the procedure established by the rules and regulations. A statute may not be disregarded on the speculation that it may be repealed or amended.

By his own affidavit, the Commissioner admits that he established interim rates in anticipation that the statutes relating to the reimbursement rates for residential health care facilities would be amended. The letter dated November 24, 1975, signed by the Director of the Bureau of Health Care Reimbursement makes it clear that the rates were not established according to statutory requirements, or according to the requirements of the rules and regulations in effect for that purpose, otherwise rate calculation sheets would have accompanied the established rates. The obvious purpose of such procedure was, of course, to foreclose the right of an administrative appeal, as authorized by section 2806(4) and rule 26.17 of the Public Health Law.

The obvious intent here was to assist the City of New York and the State in a time of fiscal crisis. The effect was to deprive the petitioners and the members of the class of income to which they were entitled according to statute and rule. While there exists a strong presumption of reasonableness as to the Commissioner's

decision, the obvious disregard herein of statutes and regulations overcomes that presumption. The case of *Matter of Sigety* v. *Ingraham* (29 NY2d 110) cited as the authority of the Commissioner to limit the reimbursement rate is not in point. In that case, there was a statutory and regulatory basis for the action of the Commissioner which is not evident here.

The petition also alleges a violation of the Federal statutes affecting the Medicaid Program. While the answer generally denies these allegations, the Commissioner's affidavit and the respondents' brief fail to respond to these allegations, thus no attempt is made to establish compliance with the Federal statutes, or to establish that the approval of the Secretary of Health, Education and Welfare is not required for the procedure adopted herein. Under the circumstances, it must be assumed that the respondents have also violated the Federal statutes.

Subsequent to the commencement of this proceeding, the Legislature amended the Public Health Law by the enactment of Chapter 76 of the Laws of 1976. Section 11 of chapter 76 amended subdivision 2 of section 2807 by adding certain subsections thereto.

Section 2(e) provides:

> "During the period beginning January first, nineteen hundred seventy-six, and ending March thirty-first, nineteen hundred seventy-seven, the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities without regard to the provisions of subdivision three of this section. The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph notwithstanding any in-

consistent provision of such section twenty-eight hundred eight."

Section 18 of chapter 76 provides that this section "shall be deemed to have been in full force and effect on and after the first day of January, nineteen hundred seventy-six."

Section 13 of chapter 76 adds a new subdivision 4 to section 2807 which provides as follows:

> "The commissioner shall notify each hospital and health related service of its approved rate at least sixty days prior to the beginning of an established rate period for which the rate is to become effective."

Section 16 of chapter 76 provides as follows:

> "The effectiveness of the provisions of subdivision four of section twenty-eight hundred seven of the public health law, as added by chapter six hundred eighty-two of the laws of nineteen hundred seventy-four, are hereby suspended and shall, for all purposes whatsoever, be deemed to have been without any force or effect from and after November first, nineteen hundred seventy-five."
>
> Section 13 of chapter 76 provides that sections 13 and 16 shall take effect immediately, provided, however, that they shall remain effective only to and including March 31, 1977; and "shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act."

Section 18 also provides as follows:

> "The state commissioners of health, social services and education shall, prior to such effective dates, take all necessary steps to inform providers and recipients of medical assistance of the provisions of this act and are authorized to take such other steps as may be necessary to effectuate the purposes of this act. This act shall apply to care, services and supplies furnished on and after the applicable effective date. This act shall not be construed

> to alter, change affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act, nor shall this act be interpreted so as to deny care, services or supplies to any individual if such care, services and supplies are necessary in order to complete a course of treatment initiated prior to the enactment of this act."

Chapter 76 was approved by the Governor on March 30, 1976.

Section 2803 (1) (c) of the Public Health Law charges the Commissioner with the duty of promulgating and publishing uniform criteria for the evaluation of residential health care facilities with respect to their compliance with the standards set forth in section 2803 based upon inspections. It also provides that the Commissioner shall devise a rating system consisting of no less than five specific rating categories, the ratings to be based upon inspections. Section 2808 requires the promulgation of regulations which tie the reimbursement rates to the ratings established pursuant to section 2803 (1) (c).

At the time of the commencement of this proceeding, the Commissioner had not implemented section 2803 (1) (c) or section 2808 except insofar as section 86.34 of the Commissioner's regulations continued the regulations for rate certification in effect on October 8, 1975, until regulations had been promulgated pursuant to sections 2807 and 2808.

The Commissioner now asserts that section 16 of Chapter 76 of the Laws of 1976 effectively eliminated the specific time framework in which the Commissioner had in which to certify new reimbursement rates, and that new reimbursement rates to be published on August 1, 1976, retroactive to January 1, 1976, render the issues raised in the petition moot. Such is not the case. The suspension of subdivision 4 of section 2808 by section 16 of Chapter 76 of the Laws of 1976 merely gives the Commissioner absolution for his violation of that section. It does not

absolve him of the duty of establishing proper rates in accordance with contractual obligations, statutes and regulations under which the Commissioner had no authority to freeze the rates at 1975 levels.

The Court has not been apprised as to whether the new reimbursement rates were actually published on August 1, 1976, or of the basis upon which such rates were determined, if published. While the Commissioner asserts such new rates were to be published on August 1, 1976, he does not assert that he has complied with the requirements of section 2803 (1) (c) by promulgating and publishing uniform criteria for evaluation of health related facilities, and by devising a rating system for such facilities. He also does not assert that he has promulgated regulations pursuant to section 2808 different than those in effect on October 8, 1975. In the absence of such implementation of these statutes, there is no basis upon which the Commissioner could publish new reimbursement rates other than upon the statutes and regulations in effect on January 1, 1976, prior to the enactment of Chapter 76 of the Laws of 1976.

There exists a further reason why the Commissioner must establish reimbursement rates based upon the statutes and regulations existing on January 1, 1976. Medicaid services are provided by nursing homes pursuant to Provider Agreements between the nursing homes and the State which provide for reimbursement at a rate established by law. The regulations in effect on January 1, 1976 (section 86.10 hereinbefore set forth) provided for certification of reimbursement rates for a twelve month calendar year period, and section 2807 (4) required notification of the approved rates at least 60 days prior to the beginning of an established rate period. These provider agreements are contracts establishing the rights, duties and obligations of the parties. While the State as the sovereign has

the power to enact new laws, it cannot do so in a manner to unilaterally amend its own contracts for its own benefit. Further, section 18 of Chapter 76 of the Laws of 1976 provides:

> "This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act * * * *."

The provisions of chapter 76 cannot, therefore, be applied retroactively so as to defeat or impair the rights, obligations and duties of the parties to these provider agreements which had accrued prior to the enactment of chapter 76.

Judgement is, therefore, awarded to the petitioners, and the members of the class for the relief sought in the petition.

Attorneys for petitioners to submit order and judgment.

All papers to the attorneys for petitioners for filing upon entry of the order herein.

Date: September

APPENDIX D

Judgment of the New York State Supreme Court entered pursuant to Memorandum Decision of the New York Court of Appeals.

STATE OF NEW YORK
SUPREME COURT – ALBANY COUNTY

LESLIE KAYE, BARUCH GLOBERMAN and SOL MALLOW, as Operators of the Sans Souci Nusing Home; EMMANUEL BIRNBAUM and DESDEMONA JONES, as Operators of the Fieldston Lodge Nursing Home; and THE NEW YORK STATE HEALTH FACILITIES ASSOCIATION, a New York not-for-profit membership corporation, suing on behalf of its member licensed nursing homes and health-related facilities located within the State of New York,

Petitioners-Appellants,

—against—

ROBERT P. WHALEN, as Commissioner of Health of the State of New York, and PETER C. GOLDMARK, as Director of the Budget of the State of New York,

Respondents-Respondents.

INDEX NO. 9111-76

The Petitioners-Appellants herein, having appealed to the Court of Appeals of the State of New York from an Order of the Appellate Division of the Supreme Court, Third Judicial Department entered in the Office of the Clerk of said Court on the 17th day of February, 1977, which Order reversed a Judgment of the Supreme Court, Albany County entered in the Office of the Clerk of Albany County on the 15th day of September, 1976, and further ordered that the Petition be dismissed, and further ordered that the preliminary injunction granted by

Appendix D — Judgment of the New York State Supreme Court entered pursuant to Memorandum Decision of the New York Court of Appeals

Order of the Appellate Division be vacated, and the Court of Appeals, after due deliberation, having rendered a decision on the 25th day of April, 1978 affirming the Order of the Appellate Division, Third Department, and an Order having been entered so affirming, it is hereby:

ADJUDGED, that the aforesaid Order of the Appellate Division be, and the same hereby is, affirmed, with costs of $194.70 to Respondents, Robert P. Whalen, as Commissioner of Health of the State of New York, and Peter Goldmark, as Director of the Budget of the State of New York, and that the Respondents have execution thereon.

s/ GUY D. PAQUIN
Clerk

DATED AND ENTERED: 5/11/78

STATE OF NEW YORK
COUNTY OF ALBANY CLERK'S OFFICE ss.:

I, GUY D. PAQUIN, Clerk of the said County, and also Clerk of the Supreme and County Courts, being Courts of Record held therein, DO HEREBY CERTIFY that I have compared the annexed copy Judg with the original thereof filed in this office on the 11 day of May 1978 and that the same is a correct transcript therefrom, and of the whole of said original.

IN TESTIMONY WHEREOF, I have hereunto set my name and affixed my official seal, this 11 day of May 1978. Guy D. Paquin, Clerk

(SEAL)

APPENDIX E

Judgment entered denying Appellants' motion for reargument before the Court of Appeals.

(SAME TITLE)

The Petitioners-Appellants herein having made a motion for reargument and for a stay pending appeal to the United States Court of Appeals, and the Court of Appeals of the State of New York, after due deliberation, having rendered a decision on the 6th day of June, 1978, ordering that the said motion be denied, with twenty dollars costs and necessary reproduction disbursements, and an order having been entered so affirming, it is hereby:

ADJUDGED, that the aforesaid motion be, and the same hereby is denied, with costs of $24.20 to Respondents, Robert P. Whalen, as Commissioner of Health of the State of New York, and Peter C. Goldmark, as Director of the Budget of the State of New York, and that the Respondents have execution thereon.

s/ GUY D. PAQUIN
Clerk

DATED:

STATE OF NEW YORK
COUNTY OF ALBANY CLERK'S OFFICE ss.:

I, GUY D. PAQUIN, Clerk of the said County, and also Clerk of the Supreme and County Courts, being Courts of Record held therein, DO HEREBY CERTIFY that I have compared the annexed copy Judgment with the original thereof filed in this office on the 16 day of June 1978 and that the same is a correct transcript therefrom, and of the whole of said original.

IN TESTIMONY WHEREOF, I have hereunto set my name and affixed my official seal, this 16 day of June 1978. Guy D. Paquin Clerk km

(SEAL)

APPENDIX F

Notice of Appeal to the United States Supreme Court entered in the New York Supreme Court, County of Albany

STATE OF NEW YORK
SUPREME COURT — COUNTY OF ALBANY

LESLIE KAYE, BARUCH GLOBERMAN, and SOL MALLOW, as Operators of the Sans Souci Nursing Home; EMANUEL BIRNBAUM and DESDEMONA JONES, as Operators of the Fieldston Lodge Nursing Home; and THE NEW YORK STATE HEALTH FACILITIES ASSOCIATION, a New York Not-For-Profit Membership Corporation, suing on behalf of its member license nursing homes and health-related facilities located within the State of New York,

Petitioners,

-against-

ROBERT P. WHALEN, as Commissioner of Health of the State of New York; and PETER C. GOLDMARK, as Director of the Budget of the State of New York,

Respondents.

NOTICE IS HEREBY GIVEN that Leslie Kaye, Baruch Globerman and Sol Mallow, as Operators of the Sans Souci Nursing Home and Emanuel Birnbaum and Desdemona Jones, as Operators of the Fieldston Lodge Nursing Home, and the New York State Health Facilities Association, Inc., Petitioners herein, hereby appeal to the Supreme Court of the United States from the final decision of the Court of Appeals of the State of New York dated April 25, 1978 which affirmed the previous decision of the Supreme Court of the State of New York (Appellate Division-Third Department) dismissing the Petition of Petitioners and from the Judgment entered pursuant thereto in the Supreme Court of the State of New York in the Office of the County Clerk of the County of Albany, New York on May 11, 1978. Petitioners also appeal from the decision of the Court of

Appendix F — Notice of Appeal to the United States Supreme Court entered in the New York Supreme Court, County of Albany

Appeals of the State of New York dated June 6, 1978 and the Judgment of the Supreme Court of the State of New York entered pursuant thereto in the Office of the Clerk of the County of Albany on June 16, 1978 denying Petitioners' Motion for reargument.

This Appeal to the Supreme Court of the United States is made pursuant to 28 USC §1257(2).

DATED: July 13, 1978

O'CONNELL AND ARONOWITZ, P.C.

By: /s/ CORNELIUS D. MURRAY
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Counsel for Amici Curiae
100 State Street
Albany NY 12207

ALBANY COUNTY CLERK
Albany County Courthouse
Albany NY 12207

HON. MICHAEL RODAK, CLERK
Supreme Court of the United States
Washington, D.C.

APPENDIX G

Notice of Appeal to the United States Supreme Court entered in the Court of Appeals of the State of New York

COURT OF APPEALS
STATE OF NEW YORK

LESLIE KAYE, BARUCH GLOBERMAN, and SOL MALLOW, as Operators of the Sans Souci Nursing Home; EMANUEL BIRNBAUM and DESDEMONA JONES, as Operators of the Fieldston Lodge Nursing Home; and THE NEW YORK STATE HEALTH FACILITIES ASSOCIATION, a New York Not-For-Profit Membership Corporation, suing on behalf of its member license nursing homes and health-related facilities located within the State of New York,

Petitioners-Appellants,

-against-

ROBERT P. WHALEN, as Commissioner of Health of the State of New York; and PETER C. GOLDMARK, as Director of the Budget of the State of New York,

Respondents.

NOTICE IS HEREBY GIVEN that Leslie Kaye, Baruch Globerman and Sol Mallow, as Operators of the Sans Souci Nursing Home and Emanuel Birnbaum and Desdemona Jones, as Operators of the Fieldston Lodge Nursing Home, and the New York State Health Facilities Association, Inc., Petitioners-Appellants herein, hereby appeal to the Supreme Court of the United States from the final decision of the Court of Appeals of the State of New York dated April 25, 1978 which affirmed the previous decision of the Supreme Court of the State of New York (Appellate Division-Third Department) dismissing the Petition of Petitioners-Appellants and from the Judgment entered pursuant thereto in the Supreme Court of the State of New York in the Office of the County Clerk of the County of Albany, New

Appendix G — Notice of Appeal to the United States Supreme Court entered in the Court of Appeals of the State of New York

York on May 11, 1978. Petitioners-Appellants also appeal from the decision of the Court of Appeals of the State of New York dated June 6, 1978 and the Judgment of the Supreme Court of the State of New York entered pursuant thereto in the Office of the Clerk of the County of Albany on June 16, 1978 denying Petitioners-Appellants' Motion for reargument.

This Appeal to the Supreme Court of the United States is made pursuant to 28 USC §1257(2).

DATED: July 13, 1978

O'CONNELL AND ARONOWITZ, P.C.

By: /s/ CORNELIUS D. MURRAY
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100 State Street
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HON. MICHAEL RODAK, CLERK
Supreme Court of the
United States
Washington DC 20543

APPENDIX H

10 NYCRR Part 86-2, the official regulations governing Medicaid reimbursement of nursing homes and other related institutions in New York State

REPORTING AND RATE CERTIFICATION FOR RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, §2808)

Section 86-2.1 Definition. As used in this Part, the term "residential health care facility" shall be deemed to include all facilities or organizations covered by the term "nursing home or health related facility" as defined in Article 28 of the Public Health Law, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and where required, has been established by the Public Health Council.

86-2.2 Financial and statistical data required. (a) Each residential health care facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Residential health care facilities certified for title XVIII (medicare) shall use the same fiscal year for title XIX (medicaid) as is used for title XVIII. All residential health care facilities must report their operations from January 1, 1977 forward on a calendar year basis.

(b) Financial and statistical reports required by this Part shall be submitted to the department and/or its agent no later than 120 days following the close of the fiscal period. Extensions of time for filing reports may be granted upon application received at least 15 days prior to the due date of the report and only in those circumstances where the residential health care facility established, by documentary evidence, that the report cannot be

filed by the due date for reasons beyond the control of the facility.

(c) In the event a residential health care facility fails to file the required financial and statistical report on or before the due dates, or as the same may be extended pursuant to paragraph (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day of the calendar month following the due date of the required report and continuing until the last day of the calendar month in which said required report is filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the Department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) A cost report must be filed in accordance with this section by each new facility for the next six month period during which the facility has had an over-all average utilization of at least 90 percent of bed capacity. This report must be filed and properly certified within 60 days following the end of the six month period covered by the report.

86-2.3 Uniform system of accounting and reporting. Residential health care facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health. Records shall be maintained by residential health care facilities

in accordance with the appropriate section of the State Hospital Code. Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with all reporting requirements.

86-2.4 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorize specific variation in such principles.

86-2.5 Accountant's certification. The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish. The requirements of this Section shall not apply to residential health care facilities operated by units of government of the State of New York.

86-2.6 Certification by operator or officer. The financial and statistical reports shall be certified by the operator or an officer of the medical facility.

86-2.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted of the records of residential health care facilities, in a manner to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (medicare-medicaid and other organizations and agencies

having audit responsibilities) to satisfy the department's auditing needs.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department. This limitation shall not apply to situations in which fraud may be involved.

(d) Residential health care facilities shall be given 30 days after the mailing of notification of audit findings to appeal such findings, by submitting data intended to justify the facility's position in the areas of disagreement. Failure by the residential health care facility to reply to such findings within the 30 day period, or to receive from the department an extension of time for reply shall be considered as acceptance of the findings.

(e) Rate revisions resulting from audit findings may be made retroactively to the period or periods during which the rates based on the periods audited were established.

(f) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions.

86-2.8 Patient days. (a) A "patient day" is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

86-2.9 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies pursuant to this part shall be for the rate period beginning January 1, 1976 and ending March 31, 1977.

86-2.10 Computation of basic rate. (a) Basic rates shall be computed on the basis of allowable fiscal and statistical data submitted by the residential health care facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs shall be made.

86-2.11 Ceilings on allowable costs for reimbursement purposes.

(a) For the purpose of establishing allowable cost ceilings for determining reimbursement rates effective January 1, 1976 for

governmental payments, skilled nursing facilities and health related facilities will be grouped separately with respect to size as indicated in (1) below and with respect to the service ratings received for those functions indicated in (i) through (v) in (2) below and by size only with respect to (vi) in (2) below:

(1) Size of facilities

(i) 50 beds and under
(ii) 51 to 99 beds
(iii) 100 to 199 beds
(iv) 200 to 299 beds
(v) over 300 beds

(2) Functions

(i) Nursing
(ii) Food-Nutrition
(iii) Leisure Time Activities
(iv) Cleanliness and Safety
(v) Social Work
(vi) Administration

(b) Allowable costs for reimbursement for any function for which a facility receives a "Good - State" rating may not exceed the 60th percentile of the perdiem range of costs as reported for the base year by all facilities receiving a "Good - State" service rating for that rated function within the size groups as indicated in (a) (1) above.

(c) Allowable costs for reimbursement for any rated function for which a facility receives a "Good - Federal" service rating may not exceed the 35th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(d) Allowable costs for reimbursement for any rated function for which a facility receives a "Needs Improvement" rating may not exceed the 25th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(e) Allowable costs for reimbursement for any rated function for which a facility receives an "Unacceptable" rating may not exceed the 10th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(f) Ceilings will not be imposed on costs for any rated function for which a facility receives a "Very Good" service rating.

(g) Allowable per diem costs for administration may not exceed the 50th percentile of the range of per diem costs reported for the base year for all facilities within the size groups indicated in (a) (1) above.

(h) In establishing the ranges of per diem costs, by function, facilities will be grouped without regard to sponsor or geographic area. An economic leveling factor developed on the basis of area salaries will be used to make the costs comparable.

(i) Any amount to be eliminated in accordance with this section in determining reimbursement rates will be equal to the excess of the total per diem costs computed from the total costs reported in the base year for the functions in (a) (2) above over the total of the functional ceilings established for the service ratings and administration of the facility.

86-2.12 Adjustments to basic computed rate.

To the allowable basic rate, computed in accordance with ceiling limitations, and prior to the addition of capital costs,

realty leases, return on net equity capital, and leases, depreciation and interest related to equipment there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a residential health care facility's cost shall be weighted based on a sampling of data by the following categories:

(i) Salaries and employee health and welfare expense to be computed based on a total of sub-weights.
(ii) Nonpayroll administrative and general expense.
(iii) Nonpayroll household and maintenance expense.
(iv) Nonpayroll dietary expense.
(v) Nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) During the rate period, the cost indicators used in determining the projection factors in establishing the current certified rates may be compared with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health, as of mid-point in the rate period. Based upon such review the Commissioner may, in his discretion either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

86-2.13 Final rates. Rate adjustments may be made to correct errors in the determination of rates.

However, errors resulting from submission of information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the commissioner's rate computation sheet. Errors resulting from the rate computation process may be corrected if brought to the attention of the commissioner within four months of receipt of the commissioner's rate computation sheet.

86-2.14 Revisions in certified rates. (a) The State Commissioner of Health may consider only those applications for prospective revisions of certified rates which are based on

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a residential health care facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 88.13;

(3) significant increases in the over-all operating costs of a residential health care facility resulting from the implementation of additional programs, staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the facility by the Commissioner;

(5) requests for waivers of any provisions of Part 88 for which waivers may be granted by the Commissioner as prescribed in specific sections; and

(6) changes in the method of providing services which result in a lower over-all cost for the services provided;

(7) requests for relief from the ceiling provisions of this part. For such relief, a residential health care facility must demonstrate that its range of approved services, patient mix, lengths of appropriate stays or other pertinent factors are direct causes for all or part of the costs in excess of the ceilings. Such relief shall not result in a rate which exceeds that based on maximum reimbursable State standards, unless a waiver of such standards is granted by the Commissioner. If relief is granted, the resulting revised rates shall become effective as of the first day of the rate period.

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(d) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the Commissioner shall notify the requesting party of his determination.

(e) In reviewing appeals for revisions to certified rates the Commissioner may refuse to accept or consider an appeal from a residential health care facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital and Planning Council in one of its facilities;

(3) where it has been determined by the Commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

In such instances subdivision (c) of this section shall not be effective until the date the appeal is accepted by the Commissioner.

(f) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(g) Any residential health care facility eligible for title XVIII (medicare) certification providing services to patients insured under title XVIII which is not, or ceases to be, a title XVIII

provider of care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

86-2.15 Rates for residential health care facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

(a) The usual and customary rates, for comparable services, in the geographic area.

(b) Satisfactory cost projections.

(c) Allowable actual expenditures.

(d) An anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

86-2.16 Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.

86-2.17 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the Commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII (medicare) program.

(b) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the Commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the Commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(f) Allowable costs shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to owners, operators or employees of residential health care facilities.

(g) Allowable costs shall not include any interest charged related to rate determination or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(h) Allowable costs shall not include the direct or indirect costs of advertising, public relations or promotion except in those instances where the advertising is specifically related to the operation of the residential health care facility and not for the purpose of attracting patients.

(i) Effective for fiscal years ending in 1976 and thereafter allowable costs per unit of service in a base year will not include any cost increases over the allowable costs in the prior year which are in excess of the inflation factor used by the Department in determining the reimbursement rate in effect during such base year, unless the cost increases in the base year resulted in a rate revision related to such year in accordance with §88.14.

(j) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(k) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the Commissioner, to be allocable to expenditures other than for public relations, advertising, or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the Commissioner.

86-2.18 Recoveries of expense. (a) Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold for use outside the residential health care facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to employees;

(5) employee cafeterias;

(6) meals provided to special nurses or patients' guests;

(7) operation of parking facilities for community convenience;

(8) lease of office and other space of concessionaires providing services not related to residential health care facility service;

(9) tuition and other payments for education service, room and board and other services not directly related to residential health care facility service.

86-2.19 Depreciation. (a) Reported depreciation based on approved historical cost of buildings, fixed equipment and improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method on plant and non-moveable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only

for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and non-moveable equipment.

(d) Residential health care facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Part. In lieu of depreciation and interest, on the loan financed portion of the facilities the State Commissioner of Health shall allow level debt service on the mortgage loan, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness.

86-2.20 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for voluntary and public residential health care facilities. For proprietary residential health care facilities, necessary interest is allowable except for those amounts related to land, building, fixed equipment and improvements thereto.

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

(d) Interest on capital debt in excess of 50 percent of the net depreciated value of buildings and fixed equipment for voluntary residential health care facilities shall not be considered an allowable cost, unless the State Commissioner of Health, as of July 1, 1971, has already finally approved the fiscal feasibility of a project, or thereafter shall have determined, after inviting written comments from interested parties that capital debt in excess of such amount is a matter of public interest and does not threaten the continued existence of the institution.

86-2.21 Capital cost reimbursement for proprietary residential health care facilities (effective January 1, 1976). (a) As used in this section the following terms shall have their respective meanings:

(1) Allowed facility cost. The term "allowed facility cost" shall mean the aggregate of the building portion and land portion determined by the Commissioner pursuant to this section.

(2) Approved book value. The term "approved book value" shall mean the total certified historical cost, net of accumulated depreciation or amortization thereof, of all assets constituting plant, non-moveable equipment and land actually used to provide necessary patient care to the extent said cost is approved by the Commissioner as reasonable, necessary and in the public interest.

(3) Approved project cost. The term "approved project cost" shall mean the aggregate of costs actually incurred by the facility for the acquisition of land and the acquisition or construction of plant and non-moveable equipment used to provide necessary patient care to the extent said costs are approved by the Commissioner as reasonable, necessary and in the public interest.

(4) Capital cost. The term "capital cost" in this section shall be related solely to the approved cost for land, building, fixed equipment and improvements thereto.

(5) Commissioner. The term "Commissioner" shall mean the State Commissioner of Health.

(6) Department. The term "Department" shall mean the State Department of Health.

(7) Facility. The term "facility" shall include every "residential health care facility" as that term is defined in Article 28 of the Public Health Law or in regulations of the Department, organized and operated on a for-profit basis.

(8) Improvement. The term "improvement" shall mean any addition to, replacement of or improvement of a capital item of plant or non-moveable equipment approved by the Commissioner as reasonable, necessary and in the public interest.

(9) Improvement cost. The term "improvement cost" shall mean the actual expenditure or portion thereof attributable to an improvement approved by the Commissioner as reasonable, necessary and in the public interest.

(10) Improvement period. The term "improvement period" shall mean the period of years represented by the greater of

(i) the remaining useful facility life as of the initial improvement year; or

(ii) the useful improvement life.

(11) Initial facility year. The term "initial facility year" shall mean the calendar year in which a facility commenced operations as determined by the Commissioner.

(12) Initial improvement year. The term "initial improvement year" shall mean the calendar year in which an improvement is first used by a facility in the provision of necessary patient care as determined by the Commissioner.

(13) Rate of return. The term "rate of return" shall mean the annual rate of return on net equity capital invested and used in the provision of patient care, as said rate is determined by the United States Department of Health, Education and Welfare as an element of reasonable cost for purposes of payments to or reimbursement of proprietary providers under Title XVIII of the federal Social Security Act.

(14) Useful facility life. The term "useful facility life" shall mean a period of forty years measured from the intial facility year.

(b) Subject to subdivision (c) of this section, the reimbursement rate of every proprietary residential health care facility certified by the Commissioner pursuant to Article 28 of the Public Health Law shall include a capital cost component determined in accordance with subdivision (d) or subdivision (e) of this section.

(c) The provisions of subdivision (b) of this section shall not apply to any facility which, as of the effective date of this section or thereafter, is within the provisions of subdivision (g) or subdivision (h) of this section.

(d) (1) Except as provided by subdivision (c) of this section and subject to the provisions of paragraph (1) and paragraph (4) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the useful facility life, a payment factor representing an amount sufficient to pay, over the useful facility life, the Building Portion of allowed facility cost together with an annual rate of return thereon, as determined by the Commissioner in the initial facility year, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed Building Portion; and

(ii) for each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement together with an annual rate of return thereon, as determined by the Commissioner in the initial improvement year, in equal constant annual payments as if each of such rate of return on the then unreimbursed amount of improvement cost of such improvement and the remainder of each such annual payment

were to be applied in reduction of the then unreimbursed amount of improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient to pay an annual rate of return, determined by the Commissioner in the initial facility year, on the Land Portion of allowed facility cost.

(2) The payment factors provided by paragraph (1) of this subdivision shall be adjusted prospectively by the Commissioner at ten year intervals measured from the initial facility year or initial improvement year. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the adjustment and utilizing such average rate of return to recompute.

(i) the payment factor to be applied pursuant to paragraph (1) (i) of this section to the then remaining unreimbursed Building Portion of allowed facility cost over the then remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed improvement cost of any improvements; and

(ii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this section.

(3) For purposes of this section the Building Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to construction or acquisition of plant and nonmoveable equipment, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(4) For purposes of this section the Land Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to the acquisition of land, as may be adjusted by the Commission pursuant to paragraph (5) of this subdivision.

(5) The Commissioner may, in his discretion, determine maximum per bed approved project costs related to the efficient production of services by a facility. For purposes of this section the facility cost of any facility shall not exceed an amount equal to the applicable maximum per bed approved project cost times the number of beds specified in the operating certificate issued to the facility by the Commissioner pursuant to Article 28 of the Public Health Law. The Commissioner shall reduce the Building Portion or Land Portion of any facility whose approved project cost exceeds the maximum determined in accordance with this subsection by the amount which the Commissioner finds attributable to such portion.

(e) (1) Except as provided in Subdivision (c) of this section and subject to the provisions of paragraphs (3), (4), (7), (8) and (9) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurred prior to the calendar year in which this section becomes

effective shall consist of the sum of the following three payment factors:

(i) for each year of the then remaining useful facility life, a payment factor representing an amount sufficient to pay, over the remaining useful facility life, the remaining unreimbursed Building Portion of allowed facility cost, together with an annual rate of return thereon determined pursuant to paragraph (2) of this section, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed amount of the Building Portion and the remainder of each such annual payment were to be applied in reduction of the Building Portion; and

(ii) For each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement, together with an annual rate of return thereon determined pursuant to paragraph (2) of this section, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued

by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient either (a) to pay an annual rate of return determined pursuant to paragraph (2) of this section on the Land Portion of allowed facility cost or (b) to reimburse the facility for the total payments or approved portion thereof made by the facility for the use of land rented pursuant to a lease which meets the specifications of subparagraphs (i), (ii) and (iii) of subdivision (h) (1) of this subpart.

(2) The rate of return used to determine the payment factors pursuant to paragraph (1) of this section shall

(i) for facilities whose initial facility year was at least five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the five years preceding the year in which this subpart becomes effective or

(ii) for facilities whose initial facility year was less than five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the years in which the facility was established by the Public Health Council and operated pursuant to an operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law.

(3) The payment factors provided by paragraph (1) of this section shall be adjusted prospectively by the Commissioner at ten year intervals measured from the year in which this subpart becomes effective. Each such adjustment shall be made by the Commissioner determining the coverage of the rates of return in each of the

five years preceding the adjustment and utilizing such average rate of return to recompute

(i) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed Building Portion of allowed facility cost over the remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this section.

(4) Notwithstanding the provisions of paragraph (1) of this section, the capital cost component for facilities whose initial facility year was more than 20 years prior to the year in which this subpart becomes effective and which are found by the Commissioner to comply in all respects with the provisions of the State Hospital Code shall

(i) for the remaining useful facility life be not less than an amount equal to $200 multiplied by the number of beds specified in the operating certificate issued to such facility by the Commissioner pursuant to Article 28 of the Public Health Law; and

(ii) for each year beyond the remaining useful facility life consist of the payment factor applicable to such facility pursuant to paragraph (1) (iii) of this subdivision.

(5) Except as provided in subsection (1) of this paragraph, for purposes of this section the Building Portion of allowed facility cost shall consist of the portion of the approved book value of a facility attributed by the Commissioner to plant and non-moveable equipment, as adjusted by the Commissioner pursuant to paragraph (7) and paragraph (8) of this subdivision.

(6) Except as provided in paragraph (9) of this subdivision, for purposes of this section the Land Portion of allowed facility cost shall consist of the portion of the approved book value of a facility attributed by the Commissioner to land, as adjusted pursuant to paragraph (7) and paragraph (8) of this section.

(7) The Commissioner shall reduce the approved book value of any facility so as to disregard prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(8) The Commissioner may, in his discretion, reduce the approved book value of the facility to take into account such factors as the age, size, location and condition of the facility.

(9) In lieu of determining allowed facility cost pursuant to paragraph (5) and Paragraph (6) of this subdivision, the Commissioner shall, based on approved project cost or approved book values of facilities of comparable age, size, location and condition, assign an allowed facility cost, and allocate the same between the Building Portion and Land Portion thereof, to

(i) every leased facility which operates under a lease which the Commissioner finds to be other

than bona fide or the terms of which are found to be other than fair and reasonable; and

(ii) every facility for which records on asset book values are not available or not verifiable to the satisfaction of the Commissioner; and

(iii) every facility which, after the effective date of this subpart, ceases to be eligible for reimbursement pursuant to subdivision (h) of this subpart; and

(iv) every facility whose construction was completed prior to the calendar year in which this subpart becomes effective and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective.

provided that this section shall not apply to any such facility which is able to provide the Commissioner with information which the Commission finds sufficient to determine its approved book value.

(f) Subject to the provisions of subdivision (g) of this subpart, the capital cost component of any facility that is sold, transferred or the subject of any other transaction after March 10, 1975 shall be determined in accordance with the provisions of this section as if such sale, transfer or other transaction had not occurred.

(g) (1) Notwithstanding the provisions of subdivision (b) and subdivision (f) of this subpart, the capital cost component of any facility shall, upon the sale or transfer of such facility to a voluntary sponsor or the conversion of such facility to a voluntary facility, be determined pursuant to sections 88.19 and 88.20 of this part and paragraph (2) of this section.

(2) The approved book value of a facility within paragraph (1) of this section, determined for purposes of sections 88.19 and 88.20 shall be determined in accordance with the provisions of this section as though such sale, transferor conversion had not occurred.

(h) (1) The provisions of subdivision of this section shall not apply to any facility which, as of the effective date of this subpart, is located in and operated from leased space pursuant to a lease

(i) which was entered into and approved for reimbursement prior to March 10, 1975; and

(ii) which the Commissioner finds to be bona fide, valid and non-cancellable; and

(iii) the terms of which the Commissioner finds to be fair and reasonable; and

(iv) the payments or portion thereof made pursuant to which are found by the Commissioner to be the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of this section shall consist of a payment factor sufficient to reimburse the facility for the total payments required under the lease thereof to the extent approved by the Commissioner pursuant to paragraph (1) of this subdivision.

86-2.22 Moveable Equipment. Necessary and reasonable expenses related to moveable equipment (depreciation computed on a straight line method or accelerated under a double declining

balance on sum-of-the years digits method, interest on indebtedness, lease etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

86-2.23 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

86-2.24 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.

86-2.25 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

86-2.26 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to a residential health care facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate shall include both the costs of the related organization in providing the services, facilities and supplies (and a return on the equity capital of the related organization).

86-2.27 Termination of service. The Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-2.7 of this Part.

86-2.28 Return on investment. In computing the allowable costs of a proprietary residential health care facility, there will be included a reasonable return on net equity capital, excluding capital invested in land, plant, fixed equipment and improvements thereto, invested for necessary and proper operation for patient care activities. The percentage to be used in computing this allowance will be a rate determined annually by the commissioner as reasonably related to the then current money market.

86-2.29 These regulations shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 1976.

APPENDIX I

NY Pub. Health Law, §2807(3) (McKinney 1977)

3. Prior to the approval of such rates, the commissioner shall determine, and certify to the superintendent of insurance and the state director of the budget, that the proposed rate schedules for payments for hospital and health-related service, including home health service, are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital or agency is located, the rate of increase or decrease of the economy in the area in which the hospital or agency is located, costs of hospitals or agencies of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exlude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service or home health service, and allowances for costs which are not specifically identified.

APPENDIX J

Sample Provider Agreement executed pursuant to 42 USC §1396a(a)(27)

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROVIDER AGREEMENT

(FULL COMPLIANCE)

The undersigned, certified by the Secretary of the Department of Health, Education, and Welfare, as eligible for Title XIX (Medicaid) agreement, shall be subject to the same terms and conditions and coterminous with the approval of eligibility as specified by the Secretary pursuant to Title XVIII, for a TWELVE-month term as being in full compliance with the standards of a "Skilled Nursing Home" as defined in Part 249 of Title 45 of the Code of Federal Regulations, in consideration of receiving payments for services provided to individuals receiving assistance under the New York State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act, hereby agree(s) as follows:

a. To keep such records as are necessary fully to disclose the extent of the services provided to such individuals receiving assistance under the said plan and

b. To furnish the New York State Department of Social Services with such information regarding any payments claimed by the nursing home for providing such services as the Department may from time to time request and

c. To insure that established written policies and practices governing admission and retention of patients within the facility reflect full compliance with regard to the provisions of Title VI of the Civil Rights Act of 1964 and additionally do not discriminate as to source of payment in admission and retention of patients in said facility.

This agreement shall continue in effect for the term indicated below and no longer, so long as the nursing home continues to be

Appendix J — Sample Provider Agreement executed pursuant to 42 USC §1396a(a)(27)

certified by the New York State Department of Health as being in full compliance with the standards of a "skilled nursing home" as defined in Part 249 of Title 45 of the Code of Federal Regulations and so long as the nursing home continues to provide services in accordance with applicable provisions of the Social Services Law of the State of New York, the Public Health Law, the rules and regulations of the Department of Social Services and the requirements of the State Hospital Code.

This coterminous agreement is not transferable or assignable.

Nothing herein shall be construed to limit or alter any contract between the undersigned and any State or Federal agency.

Effective Date: June 1, 1975 Expiration Date: May 31, 1976

Termination of your Title XVIII certification, by reason of non-compliance with the uniform conditions of participation, or voluntary withdrawal from Title XVIII will nullify your Title XIX Provider Agreement, effective the date of such termination or withdrawal.

EDP Identification # 729

Mr. Leslie Kaye, Administrator
SANS SOUCI NURSING HOME
115 Park Avenue
Yonkers, New York 10703

Name and Address of Nursing Home

120 beds

/s/ LESLIE KAYE

Authorized Signature

Date: 5/14/75

Receipt acknowledged for the New York State Department of Social Services

by: /s/ THOMAS FITZPATRICK 5/19/75

Name Date

APPENDIX K

Letter dated July 12, 1977 from HEW to New York State advising that Part 86-2 reimbursement regulations do not satisfy federal reasonable cost-related standards

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007
JUL 12 1977

(SEAL) HEALTH CARE FINANCING ADMINISTRATION

Mr. Philip L. Toia
Commissioner
NYS Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243

Refer to:

Dear Commissioner Toia:

This letter represents a response to plan submittal 77-8 (part 86-2, N.Y.S. Health Commissioner Rules) relating to proposed reimbursement methodology for payment of nursing homes services as required by 45 CFR 250.30(a)(3).

First, I want to commend the State for developing plan material that is consistent with one of the objectives of the Health Care Financing Administration, which links reasonable cost of services to quality of services. In this regard, it is the clear intent of both this department and Congress that states, like New York, have broad latitude and flexibility in developing cost finding techniques, rate-setting, and procedures for reimbursement, under 45 CFR 250.30(a)(3).

Appendix K — Letter dated July 12, 1977 from HEW to New York State advising that Part 86-2 reimbursement regulations do not satisfy federal reasonable cost-related standards

Second, with the past as prologue, the regional office is particularly pleased that the State has placed particular emphasis on ensuring that facilities would not be overpaid or underpaid.

Third, the excellent work of the *Moreland Act Commission* identified examples of weaknesses in a rate-setting system in New York we all thought to be exemplary, and we are aware of your efforts to eliminate the deficiencies.

Nonetheless, in reviewing your plan, our analysis has led us to a belief that Section 86-2.10 "computation of basic rate" does not conform to Federal requirements for "reimbursement reasonably related to cost."

Our specific concern is the manner in which the system for rating services at institutions is used in determining reimbursement rates.

Significantly, while we find the current rating system worrisome, we do agree with the overall concept of keying reimbursement to the quality of services provided. The approach is innovative and could yield the positive benefits sought relating to quality of services.

In order to develop a rating system that could be implemented in line with Federal requirements, I and my staff are available to work with you on this critical matter.

I look forward to hearing from you.

Sincerely,

/s/ WILLIAM TOBY
William Toby
Acting Medicaid Director

/s/ WILLIAM TOBY
William Toby
Acting Regional Administrator

APPENDIX L

Letter dated September 30, 1976 from HEW to New York State concerning the implementation deadline for reasonable cost-related reimbursement regulations.

SEAL

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007
SOCIAL AND REHABILITATION
SERVICE

SEP 30, 1976

William Steibel, D.D.S.
Deputy Commissioner
Division of Medical Assistance
New York State Department of
Social Services
1450 Western Avenue
Albany, New York 12243

Dear Bill:

This is in response to your September 29, 1976 letter in which you raised the question as to whether there are any restrictions in terms of statutory or regulatory requirements to New York adopting a revised rate for SNFs and ICFs on a retroactive basis.

As you know, regulations published July 1, 1976 (45 CFR 250.30 (a) (3)) require that effective July 1, 1976, payment for skilled nursing facility and intermediate care facility services must be on a reasonable cost-related basis. HEW's role in the rate-setting process is to approve and verify the methods of cost-finding established by the State. Approval of cost-finding methods takes place when State Plan amendments are sub-

mitted. The revised pages and attachments to the Title XIX State Plan are due in the Regional Office by December 31, 1976. The plan material must indicate compliance with the specific effective dates set forth for cost reporting periods, auditing activities, and payment of rates developed under the State's methods.

Prior to the publication of the July 1, 1976 regulations, there was no specific methodology of reimbursement required for SNFs and ICFs in the Title XIX State plan. The regulations (45 CFR 250.30 (b) (3) (B)) provided that the State established schedules of charges which were consistent with the intent that upper limits did not exceed amounts paid under Title XVIII for similar services.

As you can see, our regulations have not previously required DHEW approval of the reimbursement methodology developed by the States for SNFs and ICFs. Therefore, revisions to rates for periods prior to the implementation of 250.30 (a) (3), (December 31, 1976) are not contrary to Federal regulations insofar as they meet the test of not exceeding amounts paid under Title XVIII.

Sincerely,
/s/ SEYMOUR L. BUDOFF
Seymour Budoff
Associate Regional Commissioner